



Sandia Total Health administered by Blue Cross Blue Shield of New Mexico

ConnectYourCare
(subcontractor to BCBSNM for FSA/HRA)

Magellan Health Services
(subcontractor to BCBSNM for EAP)

(Employees, PreMedicare Retirees, Survivors, &
Long Term Disability (LTD) Terminees)

Program Summary

Revised: January 1, 2019

IMPORTANT

This Program Summary applies to employees and PreMedicare retirees, survivors, and Long Term Disability Terminees effective January 1, 2019.

For more information, refer to the [National Technology & Engineering Solutions of Sandia, LLC. \("NTESS"\) Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#).

The Sandia Total Health Program is maintained at the discretion of NTESS and is not intended to create a contract of employment and does not change the at will employment relationship between you and NTESS. The NTESS Board of Managers (or designated representative) reserves the right to amend (in writing) any or all provisions of the Sandia Total Health Program, and to terminate (in writing) the Sandia Total Health Program at any time without prior notice, subject to applicable collective bargaining agreements.

The Sandia Total Health Program's terms cannot be modified by written or oral statements to you from human resources representatives or other NTESS personnel.



U.S. DEPARTMENT OF
ENERGY



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Section 1. Introduction

This summary highlights healthcare benefits of the Sandia Total Health Program (“the Program”), a component of the National Technology & Engineering Solutions of Sandia, LLC. (“NTESS”) Health Benefits Plan for Employees (ERISA Plan 540) and the NTESS Health Benefits Plan for Retirees (ERISA Plan 545). This Program Summary is part of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#). It contains important information about your NTESS or “Sandia” healthcare benefits.

Certain capitalized words in this Program Summary have special meaning. These words have been defined in [Section 13: Definitions](#).

When the words “we,” “us,” and “our” are used in this document, we are referring to Sandia. When the words “you” and “your” are used throughout this document, we are referring to people who are Covered Members as defined in [Section 13: Definitions](#).

Many sections of this Program Summary are related to other sections of the Program Summary and to information contained in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#). You will not have all of the information you need by reading only one section of one booklet.

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Affordable Care Act (ACA).

To receive a paper copy of this Program Summary, other Program Summaries, the [NTESS Health Benefits Plan for Employees Summary Plan Description](#), or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#), contact HR Customer Service at 505-844-4237, option 2 or email hbesupport@mailps.custhelp.com. These documents are also available electronically at hr.sandia.gov.

Since these documents will continue to be updated, it is recommended to check back on a regular basis for the most recent version.

Section 2. Summary of Changes

The following changes are effective January 1, 2019:

Virtual visits have a \$25 copay per visit, which is not subject to the deductible, but subject to the medical out of pocket maximum. For more information, see [Section 3: Accessing Care](#).

The following are clarifications / reminders for 2019:

- Immunizations for personal travel will pay 80% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.
- The Health Reimbursement Account (HRA) claim filing period has changed. See [Section 5: Health Reimbursement Account](#) for more information.
- Qualified 213(d) expenses (which include eligible medical, dental, vision, and prescription expenses) incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.
- When using a debit card to pay for HRA claims, there are certain claims which are not automatically substantiated and require additional documentation (receipts that indicate the date of service, the vendor, the nature of the service and cost).
 - a. For unsubstantiated claims identified by the HRA administrator, you will receive 3 notifications requesting additional documentation.
 - b. Following the 3rd notice, debit cards will be inactivated until claim receipt documentation is received.
 - c. For any unsubstantiated claims remaining after the 3rd notice, the amount of the claims will be added to your W2 income and taxed accordingly.
 - d. Remember to save all FSA and HRA claim receipts.
- In order to receive HRA funding for the following year:
 - **Active employees and their spouses** must complete the online Health Assessment by logging into [Virgin Pulse](#). It must be completed by:
 - November 30 of the current year to receive funding by January 1, or
 - December 31 of the current year to receive funding after January 1
 - **PreMedicare retirees and their PreMedicare spouses, LTD Terminees and their spouses, and Surviving Spouses** must complete their Health Assessment through BCBSNM from October 1 through September 30 (of the current year).
 - **PreMedicare retirees and their spouses** that retired prior to September 30 of the current year and completed the Health Assessment(s) prior to retirement through Sandia will need to complete a new Health Assessment through BCBSNM by September 30 in order to receive funding.

Section 3. Accessing Care

This section describes how to access medical/surgical and behavioral healthcare under the Sandia Health Partner Network (SHPN), in-network and out-of-network options. Prior Authorization requirements, predetermination of benefits, accessing non-Emergency or non-Urgent Care while away from home, the Employee Assistance Program, and other general information. For information regarding the prescription drug program, refer to [Section 7: Prescription Drug Program](#).

Sandia Health Partner Network (SHPN), In-Network, and Out-of-Network Options

The medical plan portion of the Sandia Total Health Program provides you three options for accessing care: SHPN, in-network, and out-of-network. You receive a higher level of benefits under the SHPN option than under the in-network option, while you will receive the lowest level of benefits when you use out-of-network providers.

Members that reside in the Bernalillo, Sandoval, Torrance, and Valencia counties of New Mexico have out-of-network coverage under the medical plan for Covered Health Services from Presbyterian facilities and providers. Members residing outside these four counties but residing within New Mexico can visit Presbyterian facilities and providers and receive in-network benefits for Covered Health Services.

Sandia Health Partner Network (SHPN) Option

The SHPN in-network option provides you access to a smaller custom network of physicians, facilities and suppliers for a better benefit and lower Out-of-Pocket expenses for you and your dependents. To find a listing of SHPN providers, go to bcbsnm.com/sandia. DaVita Medical Group (formerly ABQ Health Partners), one of the physician groups under the SHPN, provides a dedicated one-call hotline (Ambassador Line) for Sandia: 505-262-7100. By calling this number, as the main point of contact for Sandians, you will have direct access to a dedicated representative to help navigate you to one of the ABQ Health Partner providers and to assist you with any of their healthcare services.

The advantages of using the SHPN network option include:

- Lower Coinsurance for you to pay (e.g., 10% versus 20% (in network) or 40% (out-of-network)).
- Lower Out-of-Pocket Maximums (e.g., \$2,000 versus \$2,750 (in network) or \$6,500 (out-of-network)) per Member, which includes Deductible and Coinsurance amounts paid by you).
- No balance billing by the provider.
- Certain preventive care services covered at 100%.
- Generally, no claims to file.

- Auto-pay for the patient responsibility is sent to your provider first from your FSA, if enrolled, and then your HRA.
- RAPS providers' (radiology, anesthesiology, and pathology) Covered Health Services while you are a patient at a Lovelace facility will be considered at the SHPN higher benefit level.

If your provider participates in the SHPN, he or she will obtain Prior Authorization from BCBSNM (or from the BCBSNM Behavioral Health Unit, when applicable) in the following circumstances:

- When recommending any non-Emergency admission, readmission or transfer.
- When a covered newborn stays in the hospital longer than the mother.
- Before providing or recommending services listed later in this section.

Note: you should always verify that Prior Authorization has been requested by your preferred SHPN provider for these services.

In-Network Option

Outside the SHPN, there is a broader in-network option that provides you access to physicians, facilities, and suppliers who are contracted as “Preferred Providers” with BCBSNM or other BCBS Plans to provide their services at negotiated fees. No referrals are required. Some procedures may require Prior Authorization that you are responsible for asking your physicians or treatment facility to obtain from BCBSNM. For the most updated in-network provider listings in your area, contact BCBSNM Customer Service at 877-498-7652 or access the national BCBS website at provider.bcbs.com.

The advantages of using the in-network option include:

- Lower Coinsurance for you to pay (e.g., 20% versus 40% (out-of-network))
- Lower Out-of-Pocket Maximums (e.g., \$2,750 versus \$6,500 (out-of-network) per Member, which includes Deductible and Coinsurance amounts paid by you)
- No balance billing by the provider
- Certain preventive care services covered at 100%
- Generally, no claims to file
- Auto-pay for the patient responsibility is sent to your provider from your FSA, if enrolled, and then your HRA.
- RAPS providers' (radiology, anesthesiology, and pathology) Covered Health Services while you are a patient in an in-network hospital will be considered at the in-network benefit level.

BCBSNM Preferred Providers

If the attending physician is a Preferred Provider that contracts directly with BCBSNM, obtaining Prior Authorization is not your responsibility – it is the provider’s. Preferred Providers contracting with BCBSNM must obtain Prior Authorization from BCBSNM (or from the BCBSNM Behavioral Health Unit, when applicable) in the following circumstances:

- When recommending any nonemergency admission, readmission, or transfer.
- When a covered newborn stays in the hospital longer than the mother.
- Before providing or recommending services listed later in this section.

You are not responsible for any penalties that apply when a provider who contracts directly with BCBSNM fails to obtain any needed Prior Authorization.

Preferred Providers outside New Mexico

If any Preferred Provider outside New Mexico that does not contract directly with BCBSNM recommends an admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for you. In such cases, it is **your responsibility** to ensure that Prior Authorization is obtained. If you do not, benefits may be reduced or denied, and the unpaid portion will be your responsibility. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or their Behavioral Health Unit, when applicable) is called.

Out-of-Network Option

The out-of-network option offers a lower level of benefit but enables you to get Covered Health Services from licensed, eligible providers outside the BCBS Association PPO network. No referrals are required. You are responsible for Deductibles, Coinsurance, and amounts exceeding Medicare-Approved Amounts, also referred to as balance billing. You are also responsible for filing all claims not filed by the provider.

If you are admitted to a hospital that is not in the network on an Emergency basis and services are covered, in-network benefits will be paid until you are stabilized. Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as BCBSNM confirms the treatment to be Medically Necessary.

If any provider outside New Mexico or any Non-preferred Provider recommends an admission or a service that requires Prior Authorization, the provider is not obligated to obtain the Prior Authorization for you. In such cases, it is **your responsibility** to ensure that Prior Authorization is obtained. If you do not, benefits may be reduced or denied and the unpaid portion will be your responsibility. The provider may call on your behalf, but it is your responsibility to ensure that BCBSNM (or their Behavioral Health Unit, when applicable) is called.

Note: If you do not have access to any BCBS PPO Network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-

Area Plan. When you access providers, BCBS determines who will be placed in the Out-of-Area Plan. Reimbursement in such cases is based on billed charges.

Prior Authorization Requirements for Medical Services

When you choose to receive certain services (listed below), you are responsible for notifying BCBSNM before you receive these services, otherwise coverage may be denied or reduced. BCBSNM ensures you and/or your covered family members receive the most appropriate and Cost-Effective services available.

IMPORTANT: Although a service may not be on the list of services needing Prior Authorization, in order to ensure that services and procedures will be covered, you are encouraged to obtain a predetermination of benefits from BCBSNM.

Inpatient Admissions

You or your provider must request Prior Authorization from BCBSNM for:

- Non-emergency admissions: at least five business days before admission
- Maternity delivery admissions: within 48 hours of vaginal delivery (96 hours for a C-section)
- Emergency admissions: within two business days following admission or as soon as reasonably possible

The first \$300 of Covered Charges will not be considered covered if you, your authorized representative, or your provider does not contact BCBSNM within the applicable time frames for inpatient services. An exception to this requirement would be, if you have primary healthcare coverage for these services under Medicare or another non-Sandia healthcare program and that other coverage did not deny services as being ineligible for any reason.

Note: If delivery is planned to be at home but requires admission to the hospital, notification is required.

The Prior Authorization number for inpatient care is 800-325-8334.

IMPORTANT: Providers that contract with Blue Cross Blue Shield Plans other than BCBSNM are not familiar with the Prior Authorization requirements of the Sandia Total Health Program. You are responsible for being aware of this medical plan's requirements. Call 800-325-8334 to request Prior Authorization.

Outpatient and Other Medical Services

Other non-Emergency services (whether in-network (including SHPN) or out-of-network) that require BCBSNM Prior Authorization are listed below. Your benefits for services listed below, if determined to be covered and Medically Necessary will be denied if Prior Authorization is not received (except that the penalty for failure to obtain Prior Authorization for Medically Necessary air ambulance is a \$300 reduction in benefits).

- Air ambulance services (except in an Emergency)

- Cardiac and pulmonary rehabilitation
- Cardiac CT scans
- Clinical trials
- Congenital heart disease services
- Dental services stemming from illness or injury
- Durable Medical Equipment for items with a purchase or cumulative rental value of \$1,000 or more
 - Insulin pumps and continuous glucose monitoring systems, regardless of cost
- Enteral nutrition/nutritional supplements
- Genetic testing (including breast cancer genetic testing (BRACA))
- Hearing aids/exams and/or cochlear implants
- Home dialysis
- Home healthcare
- Hospice care
- Immunoglobulin infusion (IVIG) therapy
- Infertility treatment
- Injectable Outpatient chemotherapy
- Obesity surgery
- Positron emission tomography (PET) scans
- Maternity care that exceeds the delivery time frames as described in [Section 6: Covered Medical Plan Services / Limitations](#). Note that if delivery is at home but requires admission to the hospital, notification is required.
- Reconstructive procedures
- Short-term rehabilitation (includes inpatient rehabilitation facility, Skilled Nursing Facility, Outpatient physical, occupational and speech therapy)
- Sleep disorder studies
- Transplant services, including pre-transplant evaluation
 - Travel and lodging related to a service eligible for such coverage under the Blue Distinction program (explained later in this section under [Provider Networks](#).)

Prior Authorization requirements apply to in-network (including SHPN) and out-of-network services, providers, and facilities. Prior Authorization for the above-mentioned medical care services can be requested by calling BCBSNM at 800-325-8334.

Predetermination

Although you are not required to obtain Prior Authorization for the following procedures, you are encouraged to notify BCBSNM Customer Service prior to receiving the following services in order for BCBSNM Customer Service to determine if they are covered healthcare services:

- Blepharoplasty (surgery to correct eyelids)
- Vein stripping, ligation, VNUS® Closure, and sclerotherapy (an injection of a chemical to treat varicose veins)
- Any surgery for the diagnosis “ptosis”
- Bunionectomy
- Carpal tunnel repair
- Cholecystectomy
- Intradiscal electrothermal annuloplasty (IDET)
- Sclerotherapy
- Septoplasty
- Surgery – only for the following Outpatient surgeries: diagnostic catheterization and electrophysiology implant and sleep apnea surgeries
- Therapeutics – only for the following services: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound.
- Uvulopalatopharyngoplasty (UPPP)
- Outpatient hysterectomy

These services will not be covered when determined to be Cosmetic Procedures or not Medically Necessary and you may be responsible for the entire cost.

Prior Authorization for Behavioral Health

Prior Authorization for behavioral health (mental health or chemical dependency) is required before receiving inpatient and Outpatient services whether in-network (including SHPN) or out-of-network.

If Prior Authorization is not obtained, a \$300 penalty or a denial of claims will occur if you, a family member, or your provider does not contact the BCBSNM Behavioral Health Unit (BHU) within the applicable time frames for the inpatient services listed below. An exception to this requirement would be if you have primary healthcare coverage for these services under Medicare or another non-Sandia healthcare program.

- Applied Behavioral Analysis (ABA) therapy for Autism Spectrum Disorders (ASD)
- Inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility)
- Intensive Outpatient Program treatment
- Psychological testing.

You or your provider must request Prior Authorization from BCBSNM:

- For non-Emergency admissions: at least five business days before admission
- For Emergency admissions: within two business days following admission, or as soon as is reasonably possible

Most of the time the SHPN or in-network provider will obtain Prior Authorization, however, it is ultimately your responsibility to call the BHU at 888-898-0070 to initiate the review process whether you or your covered family member are using in- or out-of-network services or facilities.

Even when you are not required to call for Prior Authorization, please call the BCBSNM BHU at the phone number listed on the back of your ID card for predetermination of Outpatient service benefits. The BHU will coordinate covered services with a network provider near you. **If you do not call, benefits for covered services may be reduced or denied.**

Your provider may be asked to submit clinical information in order to obtain Prior Authorization for the Outpatient services you are planning to receive. Services may be authorized or may be denied based on the clinical information received. (Clinical information is information based on actual observation and treatment of a particular patient.)

If Prior Authorization is not obtained before you receive Outpatient services, your claims may be denied as being **not Medically Necessary**. In such cases, **you may be responsible for all charges**. Therefore, you should make sure that you (or your provider) have obtained Prior Authorization when required or predetermination of benefits when not required *before* you start Outpatient treatment.

IMPORTANT: If you are planning on using an out-of-network provider for inpatient or Partial Hospitalization/Day treatments, Residential Treatment Facility, or Intensive Outpatient Program, remember that you must call the BCBSNM Behavioral Health Unit and get Prior Authorization. Please note that out-of-network providers for these services may require up-front payment and may not cooperate with the BCBSNM Behavioral Health Unit regarding the Prior Authorization process; therefore, your coverage may be reduced or denied.

How Prior Authorization Works

When you or your treating healthcare professional call for a Prior Authorization, the BCBSNM health services staff will ask for information about your medical condition, the proposed treatment plan, and the estimated length of stay (if you are being admitted). The Health Services staff will evaluate the information and notify the attending physician and the facility if benefits for the proposed hospitalization or other service are approved. If the

admission or other service is not authorized, you may appeal the decision. For more information, refer to [Section 11: How to File an Appeal](#).

BCBSNM initially determines whether the service is or is not Medically Necessary. This standard review is completed within 15 working days (an expedited review is completed within 24 hours).

Predetermination of Benefits

IMPORTANT: Just because a service or procedure does not require Prior Authorization does not mean it is covered. In order to ensure that services and procedures are covered, you are encouraged to obtain a predetermination of benefits as described below.

The Sandia Total Health Program covers a wide range of medical care treatments and procedures. However, medical treatments that are Investigational, Experimental, or Unproven to be medically effective are **not** covered by the Sandia Total Health Program. Contact BCBSNM before incurring charges that may not be covered.

In addition, some services may be covered only under certain circumstances and/or may be limited in scope, including but not limited to temporomandibular joint (TMJ) syndrome, procedures that may have a cosmetic effect, and unproven therapies. Predetermination of benefits is recommended to help you determine your Out-of-Pocket Maximum expense. Also, some services require Prior Authorization as described earlier in this section; therefore, when in doubt, it is important that you call BCBSNM for information on benefits. If you have any questions about how to obtain a predetermination of benefits, contact BCBSNM Customer Service at 877-498-7652.

Provider Networks

SHPN

Your Sandia Total Health Program provides a new higher benefit level when accessing an SHPN provider. The SHPN is an exclusive network of Preferred Providers that have contracted with BCBSNM for Sandia in the greater Albuquerque area.

In the greater Albuquerque area, the physicians, hospitals, and other healthcare providers/facilities participating in the SHPN network are affiliated with the Lovelace Health System, DaVita Medical Group and direct agreements with various community providers including behavioral health, laboratories, acupuncture, chiropractors, etc.

Sandia and BCBSNM cannot guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Sandia Total Health covers or pays.

Blue Cross Blue Shield PPO

Your Sandia Total Health Program provides your benefits under agreement with an exclusive network of Preferred Providers that contract with Blue Cross Blue Shield (BCBS) Plans throughout the United States and around the world. When you need non-Emergency healthcare

you must choose a provider from the national BCBS Preferred Provider Option (PPO) network to receive benefits at the in-network benefit level. You may access PPO providers in most areas nationwide.

In the greater Albuquerque area, the physicians, hospitals, and other healthcare providers/facilities participating in the BCBSNM PPO network are affiliated with Lovelace Health System and the University of New Mexico hospitals. In some cases, BCBSNM has established direct contracts with other providers. The PPO providers work with BCBSNM to organize an effective and efficient healthcare delivery system. Outside the greater Albuquerque area, BCBSNM has also contracted with providers in New Mexico to offer in-network care.

The BCBS PPO network providers are contracted by BCBS Plans. They are responsible for maintaining their provider networks. Neither Sandia nor BCBSNM nor Health Care Service Corporation (HCSC) can guarantee quality of care. Employees always have the choice of what services they receive and who provides their healthcare regardless of what the Sandia Total Health covers or pays.

Out-of-Area Plan

If you do not have access to any BCBS PPO in-network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. BCBS determines who will be placed in the Out-of-Area Plan. Reimbursement of covered out-of-network care is based on billed charges in such cases. You will be responsible for obtaining Prior Authorization and for filing all claims for medical plan services received under the Out-of-Area Plan from out-of-network providers.

Network Gap Exception

The Sandia Total Health Program has a Network Gap Exception provision for Covered Health Services. Under this provision, if there are no in-network providers in the required specialty within a 30-mile radius from your home, contact BCBSNM prior to receiving the service to request in-network benefits for Covered Health Services provided by an out-of-network provider. You will be responsible for obtaining Prior Authorization and for filing all claims for medical plan services received from out-of-network providers.

Transition of Care/Special Circumstances

If your healthcare provider leaves the BCBSNM provider network (for reasons other than medical competence or professional behavior) or if you are a new Member and your provider is not in the BCBS Plans PPO network when you enroll, BCBSNM may authorize you to continue an ongoing course of treatment with the provider for a transitional period of time of not less 90 days during which that provider's covered services will be eligible for benefits. (If necessary and ordered by the treating provider, BCBSNM may also authorize transitional care from other non-network providers.)

The period will be sufficient to permit coordinated transition planning consistent with your condition and needs. Special provisions may apply if the required transitional period exceeds 90 days. If you have entered the third trimester of pregnancy at the effective date of enrollment, the transitional period will include post-partum care directly related to the delivery. Call BCBSNM Customer Service for more details at 877-498-7652.

In addition, you may be eligible for in-network benefits for a previously authorized infertility treatment currently in progress with an out-of-network provider. Also, transplant patients and patients who are on a waiting list to receive an organ or bone marrow, may be eligible for in-network benefits for covered services related to a recent or upcoming bone marrow or organ transplant received from an out-of-network provider. Call BCBSNM Customer Service for more details at 877-498-7652.

Note: If your provider is interested in becoming an in-network provider, the provider can call BCBSNM Customer Service to inquire about the process.

Finding Network Providers

Provider directories list providers, facilities, and auxiliary services that have contracted to participate in the SHPN or the BCBSNM Preferred Provider Option (PPO) network. You can select your physician from family care physicians, internists, pediatricians, and other Specialists. Remember, by selecting an SHPN provider, you will have a better benefit and lower out of pocket expenses.

To obtain a hard copy BCBS PPO provider directory, at no cost to you, for any state within the United States, you can contact BCBSNM Customer Service at 877-498-7652. Directories are current as of the date printed. The provider networks change often. For the most current information, it is recommended that you register on to the BCBSNM website and use the online provider search at bcbsnm.com/sandia for an SHPN and PPO provider for an up-to-date provider listing.

Provider Searches Online

To search for an SHPN or PPO provider online, go to bcbsnm.com/sandia. All that is needed is access to the Internet. Register at this website and create your own username and password (have your ID card handy). You will need your group and Member ID numbers to fill in the information on the Blue Access Members (BAM) registration page.

- Log on (you will need to register)
- Search for physicians and facilities by street address, ZIP Code, or provider name
- Select **Search**
- To find a hospital, select **Hospital** under the Specialty Categories
- To find behavioral health providers, select **Behavioral Health** under the Specialty Categories.

If You Are Outside New Mexico

The BlueCard Program provides access to a nationwide network of providers. In most cases, when you travel or live outside the BCBSNM services area, you can take advantage of savings that the local Blue Plan has negotiated with doctors and hospitals in the area. You will receive in-network benefits for Covered Health Services received from Preferred Providers throughout the United States and around the world.

Take your BCBSNM Member ID card while you are on travel. Your ID card is required for providers to determine your medical coverage. The back of your BCBSNM Member ID card has the toll-free numbers available to you for assistance concerning your medical coverage and Pre-authorizations.

1. Always carry your current BCBSNM Member ID card.
2. In an Emergency, go directly to the nearest hospital.
3. To find doctors and hospitals nearby, call BlueCard Access® at 800-810-2583 or visit the BlueCard Doctor and Hospital Finder at provider.bcbs.com. This website includes maps and directions to a provider's location.
4. Call BCBSNM for Prior Authorization, if necessary. The phone number is on the back of your Member ID card. This Prior Authorization number is different from the BlueCard Access number mentioned above.
5. When you arrive at the Preferred Provider's office or at the Preferred Provider hospital, show the provider your BCBSNM Member ID card.

After you receive care from a Blue Plan PPO network provider, you should:

- Not have to complete any claims forms.
- Not have to pay up front for medical services, except for the usual Out-of-Pocket Maximum expenses (noncovered services, Deductible, or Coinsurance).
- Receive an Explanation of Benefits (EOB) from BCBSNM.

Traveling Outside the United States

1. Verify your benefits with BCBSNM before leaving the United States.
2. Always carry your current BCBSNM Member ID card.
3. In an Emergency, go directly to the nearest hospital.
4. Call the BlueCard Worldwide Service Center at 800-810-2583 or call collect: 804-673-1177. BlueCard Worldwide is available 24 hours a day, 7 days a week for information on doctors, hospitals, and other healthcare professionals and for medical assistance services around the world. An assistance coordinator, in conjunction with a medical professional, will help arrange a doctor's appointment or hospitalization, if necessary.
5. If you need to be hospitalized, call BCBSNM for Prior Authorization. You can find the number on the back of your Member ID card. **Note:** The number for Prior Authorization is different from the provider locator number.

6. Pay for any inpatient, Outpatient, or other professional medical care received while traveling outside the United States and as soon as you return home, file your claim.
7. To submit a claim, complete an International Claim Form and send it to the address on the BCBS International Claim Form. You may find the claim form on BCBSNM's website bcbsnm.com/sandia.

Blue Distinction Center for Specialty Care Programs

Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield companies to medical facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organization's recommendations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of healthcare nationwide.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care®, facilities that BCBS recognizes for their distinguished clinical care and processes in areas such as:

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplants

You are not required to use a Blue Distinction Center for treatment of the above-mentioned conditions. However, through the Blue Distinction programs you may be eligible for travel and lodging benefits.

IMPORTANT: Prior Authorization must be requested from BCBSNM before you travel to a Blue Distinction center for cardiac care, cancer, or transplants. If authorized, a BCBSNM case manager will be assigned to you (the covered patient) and, in the case of a transplant, you must contact the case manager with the results of the evaluation. You must ensure that Prior Authorization for the actual admission is received. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

For more information on the Blue Distinction program or to find a specialty care facility go to: http://www.bcbsnm.com/sandia/providers/blue_distinction.html.

You may be referred by a physician to a Blue Distinction Center or you may contact the Health Services department at 800-325-8334 (select "Sandia" option #3 from the menu) if you have questions about this program. The Care Coordinator will help you find treatment resources using the Blue Distinction Center, facilitate an introduction to the case manager at the facility, and continue to follow your progress and care throughout the course of treatment.

IMPORTANT: For travel and lodging services to be covered, the patient must be receiving covered cancer, transplant, or cardiac care services at a designated facility through a Blue Distinction Center for Specialty Care Program.

The Sandia Total Health Program covers expenses with Prior Authorization approval for travel and lodging related to a covered transplant, cancer treatment, or heart condition treatment as follows:

- Transportation of the Member (covered patient) and one companion who is traveling on the same day(s) to and/or from the site of the treatment center
- Expenses for lodging for the patient (while not a hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion
- If the patient is an enrolled minor child (i.e., under the age of 18), the transportation expenses of two companions will be covered, and lodging expenses will be reimbursed at a per diem rate of up to \$100 per day

Travel and lodging expenses are only available if the covered patient lives more than 50 miles from the designated Blue Distinction Centers for Specialty Care facility that is being accessed for covered cancer, transplant, or cardiac care services through the Blue Distinction program. BCBSNM must receive valid receipts for such charges before you will be reimbursed.

Examples of travel expenses may include:

- Airfare at coach rate
- Taxi or ground transportation and/or
- Mileage reimbursement at the IRS rate for the most direct route between the patient's home and designated Blue Distinction Centers for Specialty Care facility

A combined overall maximum benefit of \$10,000 per covered recipient applies for all travel and lodging expenses reimbursed under this program in connection with all treatments during the entire period that recipient is covered under this provision of the medical plan.

Virtual Visits (MD Live)

Virtual visits for Covered Health Services include the diagnosis and treatment of low acuity medical conditions for Covered Persons such as:

- Allergies/asthma
- Bladder infection/urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Ear infection
- Fever
- Joint aches
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomach ache

These services are provided through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide

communication of medical information in real-time between the patient and a distant Physician, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through the MD Live portal at mdlive.com/sandia. You will need your Member ID number located on your BCBSNM insurance card to register your account. There is a \$25 copay for virtual visit services that do not apply to the Deductible, but apply to the out-of-pocket maximum.

Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

24/7 Nurseline

Questions about health can come up at any time, which is why it is important to have easy access to a trusted source of information and support 24 hours every day. With BCBSNM 24/7 Nurseline, you have such a source – available through telephone conversations, the Internet, or informational recorded messages.

BCBSNM's 24/7 Nurseline provides you with a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week, for routine or urgent health concerns.

Call 800-973-6329 to learn more about:

- A recent diagnosis
- A minor Illness or Injury
- Men's, women's, and children's wellness
- How to take prescription drugs safely
- What questions to ask your doctor before a visit
- For help understanding your test results
- Information that can help you decide when the Emergency room, Urgent Care, a doctor visit, or self-care is appropriate
- Self-care tips and treatment options
- Healthy living habits
- Any other health related topic

IMPORTANT: If you have a Medical Emergency, call 911.

Nurseline Audio Health Library

BCBSNM's Nurseline gives you another convenient way to access health information through informational recorded messages. Call 800-973-6329 to listen to one of the Health Information Library's over 1,100 recorded messages.

Special Beginnings[®] Maternity Program

Members must enroll in Special Beginnings[®] to participate in the full program. Call 888-421-7781 within the first trimester of pregnancy. Members who enroll in the program will receive:

- 24-hour, toll-free phone access and support
- Ongoing personal communication with program staff
- Educational health information covering pregnancy and infant care topics
- A pregnancy website with useful information and tools
- Safe Beginnings – discounts available for baby-related products

Case Management Program

When BCBSNM helps you, your doctor, and other providers for major services, it is called “case management.” When you have a need for many long-term services or services for more than one condition, BCBSNM case management for medical healthcare uses a team of medical social workers and nurses (case managers) to help you make sure you are getting the help you need.

Case managers are there to help if you:

- Have special healthcare needs
- Need help with a lot of different appointments or getting community services not covered by this program
- Are going to have a transplant or another serious operation
- Have a high-risk pregnancy or having problems with your pregnancy

Case managers work closely with your doctor to develop a care plan, which will help meet your personal medical needs.

Care Coordination for Special Healthcare Needs

Some Members need extra help with their healthcare, may have long-term health problems and need more healthcare services than most Members, and/or may have physical or mental health problems that limit their ability to function. BCBSNM has programs to help Members with special healthcare needs, whether at home or in the hospital. For example, if you have special healthcare needs, the Prior Authorization you receive for equipment and medical supplies may be valid for longer than usual so that your doctor doesn't have to order them so often for you.

If you believe you or your covered family member has special healthcare needs, please call a BCBSNM case manager, who can provide you a list of resources to help you with special needs. BCBSNM also provides education for Members with special healthcare needs and their care givers. Programs include dealing with stress and information help both you and your family cope with a chronic illness.

If you have special needs, care coordination helps you by:

- Assigning a person at BCBSNM who is responsible for coordinating your healthcare services
- Making sure you have access to providers who are experts for Members with special needs
- Helping you schedule services for complex care, finding community resources such as the local food bank, housing, etc., and helping you get prepared in case of an Emergency
- Helping with coordinating health services between doctors in the network as well as facilities in the Blue Distinction programs for cancer treatment and transplants
- Making sure case management is provided when needed

You may call BCBSNM case management at 800-325-8334.

Disease Management Program

The disease management program's goal is to assist Members with chronic health conditions by providing resources and education designed to improve health status and quality of life. Blue Care Advisors (credentialed nurses) are able to customize the intervention based on each Member's unique needs. Interventions include written education, automated telephone messages, web-based support, tools for self-management, monitoring tools and, when appropriate, one-on-one telephonic coaching and education.

This disease management program is a voluntary program that helps you manage chronic conditions such as:

- Asthma
- Diabetes
- Hypertension
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)

Healthcare Fraud Information

Healthcare and insurance fraud results in cost increases for healthcare plans. You can help by:

- Being wary of offers to waive copays, Coinsurance, and Deductibles. These costs are passed on to you eventually.
- Being wary of mobile health testing labs. Ask what your healthcare insurance will be charged for the tests.

- Reviewing the bills from your providers and the Explanation of Benefits (EOB) form you receive from BCBSNM. Verify that services for all charges were received. If there are any discrepancies, call BCBSNM Customer Service.

Be very cautious about giving information about your healthcare insurance over the phone. If you suspect fraud, contact the BCBSNM Fraud Hotline at 888-841-7998.

Employee Assistance Program

Magellan Health Services is the administrator of the offsite Employee Assistance Program (EAP) for Sandia Total Health Program Members. Short-term counseling services provided under the EAP include help with all types of life issues such as parenting or relationship issues, personal improvement, work issues, emotional issues, and stress. The EAP provides assessments, referrals, and follow-up to you if you are experiencing impairment from personal concerns. Your EAP also provides online tools and resources such as a comprehensive library of articles, screening and self-assessment tools, tip sheets, and personalized improvement plans. The EAP services are provided to you at no additional cost.

Accessing EAP Services

For help identifying an in-network EAP counselor, contact Magellan at 800-424-0320 or visit www.magellanhealth.com/member. You will create your own username and password. After registration, you can locate a provider by zip code and distance in miles from your home, office, or any other start location. The Provider Search will list how many providers were found according to your search criteria. Providers for the Employee Assistance Program include therapists, social workers, and psychologists.

You may click **View detail** under each provider to view the provider's languages spoken, ages treated, and their specialties.

EAP Services and Prior Authorization Requirements

Contact Magellan Health Services at 800-424-0320 to receive Prior Authorization for EAP services. Your EAP benefit allows up to eight visits per calendar year (California Members are eligible for up to three EAP visits every six months) to an offsite, in-network EAP provider at no cost to you. You are responsible for contacting Magellan Health Services prior to receiving any EAP services.

Note: Retirees, surviving spouses, and LTD terminees and their covered dependents are not eligible for EAP benefits.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When you visit an EAP Counselor for the first time, confidentiality is described in more detail.

Section 4. Deductibles, Coinsurance, Out-of-Pocket Limits, and Lifetime Limits

This section summarizes the annual Deductibles and Out-of-Pocket Limits, as well as any Coinsurance that applies to the SHPN, in-network option and the out-of-network option. In addition, this section describes any lifetime limits under the Sandia Total Health Program.

Note: If you do not have access to any BCBS PPO Network providers within a 30-mile radius of your home, you will be covered under the in-network level of benefits under the Out-of-Area Plan. When you access providers, BCBS determines who will be included in the Out-of-Area Plan. Reimbursement in such cases is based on billed charges.

Deductibles

This section describes your Deductibles. You must first pay the annual Deductible before the Program begins to pay for Covered Health Services. When you meet the full Deductible amount, the Sandia Total Health Program begins to pay for Covered Charges at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments.

If you retire mid-year and are PreMedicare, any amounts applied towards your Deductibles under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from the Kaiser Permanente Program to this Program), any amounts applied towards your Deductible under the Kaiser Permanente will be applied to this program; however, you must contact Kaiser Permanente to have your Deductible amount transferred.

The following charges do not apply to the annual Deductible: amounts above the Medicare-Approved Amount, charges not covered by the Sandia Total Health Program, prescription drug Coinsurance, virtual visit copay, and charges incurred because of failure to obtain required Prior Authorization.

SHPN In-Network	BCBS PPO In-Network	Out-of-Network
\$500 Primary Covered Member Only	\$750 Primary Covered Member Only	\$2,000 Primary Covered Member Only
\$1,000 Primary Covered Member + either Spouse* or Child(ren)	\$1,500 Primary Covered Member + either Spouse* or Child(ren)	\$4,000 Primary Covered Member + either Spouse* or Child(ren)
\$1,500 Primary Covered Member + Spouse + Child(ren) (also referred to as family)	\$2,250 Primary Covered Member + Spouse + Child(ren) (also referred to as family)	\$6,000 Primary Covered Member + Spouse + Child(ren) (also referred to as family)

Note: The Deductibles cross-apply between the SHPN and In-Network only. The Deductibles do not cross-apply between in-network and out-of-network and SHPN and out-of-network. BCBSNM will notify you via the Explanation of Benefits form when the Deductible has been reached. You can always view your personal plan information online via Blue Access for Members portal. Visit bcbsnm.com/sandia.

Each family member may contribute toward the family Deductible based on usage. However, contribution maximums are limited to the individual Deductible amount.

After the total combined Deductible amount for an entire family reaches three times the individual Deductible amount, the family Deductible is satisfied. No more than the individual Deductible amount will be applied to the family Deductible per Member.

SHPN Example: An employee has a family of five Members. The SHPN Deductible for this family is \$1,500. Early in the calendar year, the father and mother each incurred expenses of \$700 and \$500, respectively. Subsequent to their treatment, their three children incurred expenses as follows: first child, \$500; second child, \$1,000; third child, \$200. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The individuals contribute to the SHPN Deductible as follows:

SHPN Deductible Example			
	Expenses Incurred	Individual Limit SHPN	Allowable Contribution
Father	\$700	\$500	\$500
Mother	\$500	\$500	\$500
1st Child	\$500	\$500	\$500
2nd Child	\$1,000	\$500	\$0
3rd Child	\$200	\$500	\$0
		Total:	\$1,500

After these charges are applied to the family Deductible, no additional charges are applied even though some family members have not met their individual Deductibles.

BCBS PPO In-Network Example: An employee has a family of five Members. The BCBS PPO in-network Deductible for this family is \$2,250. Early in the calendar year, the father and mother each incurred expenses of \$1,000 and \$500, respectively. Then the three children incurred expenses as follows: first child, \$500; second child, \$1,000; third child, \$200. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The individuals contribute to the in-network Deductible as follows:

BCBS PPO In-Network Deductible Example			
	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$1,000	\$750	\$750
Mother	\$500	\$750	\$500
1st Child	\$500	\$750	\$500
2nd Child	\$1,000	\$750	\$500
3rd Child	\$200	\$750	\$0
		Total:	\$2,250

After these charges are applied to the family Deductible, no additional charges are applied even though some family members have not met their individual Deductibles.

Deductible Cross-Application Example: An employee has a family of five Members. Early in the calendar year, the father and mother used SHPN providers each incurring expenses of \$750 and \$500, respectively. Through the SHPN the first child incurs \$1,000 of expenses, the second child incurs \$200 of expenses, and the third child incurs \$150 of expenses. The mother, father and first child contribute \$500 to the SHPN family Deductible of \$1,500. Since the family SHPN Deductible has been met, the second and third children have already met their individual Deductibles for SHPN services. Subsequently, each Member incurred expenses via BCBS PPO in-network providers. The father and mother each had \$1,000 of expenses. The first child has \$750 of expenses; the second child has \$100 of expenses; and the third child has \$200 of expenses. These expenses are determined to be Covered Charges and are applied to the Deductible by the claims administrator in the order of receipt of the claims. The table below illustrates the cross application of the SHPN and in-network Deductible:

Deductible Cross-Application Example						
	SHPN			BCBS PPO		
	Expenses Incurred	Individual Limit	Allowable Contribution	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$750	\$500	\$500	\$1,000	\$750	\$250*
Mother	\$500	\$500	\$500	\$1,000	\$750	\$250*
1st Child	\$1,000	\$500	\$500	\$750	\$750	\$250*
2nd Child	\$200	\$500	\$0	\$100	\$750	\$0
3rd Child	\$150	\$500	\$0	\$200	\$750	\$0
		Total:	\$1,500		Total:	\$500
*The \$500 deductible that was applied under the SHPN is applied towards the in-network Deductible.						

Deductibles for Admissions Spanning Two Calendar Years

If a Deductible has been met while you are an inpatient and the admission continues into a new year, no additional Deductible is applied to that admission’s Covered Health Services. However, all other services received during the new year are subject to the applicable Deductible for the new year.

Coinsurance

In addition to your Deductible, if applicable, you pay Coinsurance of 10% of the Covered Charge for the SHPN, or 20% of the Covered Charge for BCBS PPO in-network services, and 40% of the Covered Charge for out-of-network services. Please be aware: the difference between the Covered Charge and a provider’s billed charge can be significant; an out-of-network provider can bill you for this difference.

Certain preventive care as outlined under [Coverage Details](#) is provided at 100% coverage when you receive the services from an in-network provider, or if you receive services out-of-network, coverage is at 60% of the Medicare-Approved Amount, after the Deductible (out-of-network balance billing may apply). For information on non-covered services, refer to [Section 8: What’s Not Covered – Exclusions](#).

IMPORTANT: You are responsible for any amount above the Medicare-Approved Amount if you receive services out-of-network. Some services require Prior Authorization, otherwise you will receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to [Section 3: Accessing Care](#).

Out-of-Pocket Limit

This section describes your Out-of-Pocket Limits.

Note that Out-of-Pocket Limits are not pro-rated for mid-year enrollments.

If you retire mid-year and are PreMedicare, any amounts applied towards your Out-of-Pocket Limits under your employee coverage will transfer to your retiree coverage.

If you change medical plans mid-year (e.g. you move from Kaiser Permanente to this Program), any amounts applied towards your Out-of-Pocket Limit under the Kaiser Program will be applied under this Program; however, you will need to contact Kaiser to have the amount transferred).

Covered Medical Plan Expenses Administered by BCBSNM

Annual Out-of-Pocket Limits		
SHPN In-Network	BCBS PPO In-Network	Out-of-Network
\$2,000 Primary Covered Member Only	\$2,750 Primary Covered Member Only	\$6,500 Primary Covered Member Only
\$4,000 Primary Covered Member + either Spouse* or Child(ren)	\$5,500 Primary Covered Member + either Spouse* or Child(ren)	\$13,000 Primary Covered Member + either Spouse* or Child(ren)
\$6,000 Primary Covered Member + Spouse* + Child(ren) (also referred to as family)	\$8,250 Primary Covered Member + Spouse* + Child(ren) (also referred to as family)	\$19,500 Primary Covered Member + Spouse* + Child(ren) (also referred to as family)
Note: the annual Out-of-Pocket Limit includes the Deductible and Coinsurance.		

IMPORTANT: The Out-of-Pocket Limits do cross apply between SHPN and In-Network only. The Out-of-Pocket Limits do not cross apply between in-network and out-of-network or SHPN and out-of-network. BCBS will notify you via the Explanation of Benefits form when the Out-of-Pocket Limit has been reached.

With some exceptions (outlined above), no additional Coinsurance will be required for the remainder of the calendar year after you reach the applicable annual Out-of-Pocket Limit under the medical plan:

- For you: when you use the SHPN or in-network option and incur your SHPN or in-network Out-of-Pocket Limit for Covered Charges
- For you (and your spouse); or you (and your child(ren)): when you (and your spouse); or you (and your child(ren)) use the SHPN or in-network option and incurs the SHPN or in-network Out-of-Pocket Limit for Covered Charges
- For the family: when your family uses the SHPN or in-network option and incurs the SHPN or in-network Out-of-Pocket Limit for Covered Charges
- For you: when you use the out-of-network option and incur your out-of-network Out-of-Pocket Limit for Covered Charges
- For you (and your spouse); or you (and your child(ren)): when you (and your spouse); or you (and your child(ren)) uses the out-of-network option and incurs the out-of-network Out-of-Pocket Limit for Covered Charges
- For the family: when your family use the out-of-network option and incurs the out-of-network Out-of-Pocket Limit for Covered Charges

SHPN Example: An employee has a family of four Members. The SHPN Out-of-Pocket Limit is \$6,000. During the calendar year, the father and mother each incurred expenses (through Deductibles/Coinsurance) of \$3,000 and \$4,000, respectively. The first and second child incurred expenses (through Deductibles/Coinsurance) of \$2,000 and \$1,000 respectively. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Limit by the claims administrator in the order of receipt of the claims. The individuals contribute to the SHPN Out-of-Pocket Limit as follows:

Out-of-Pocket Limit Example			
	Expenses Incurred Through Deductible and Coinsurance	Individual Out-of-Pocket Limit	Allowable Contributions
Father	\$3,000	\$2,000	\$2,000
Mother	\$4,000	\$2,000	\$2,000
1st Child	\$2,000	\$2,000	\$2,000
2nd Child	\$1,000	\$2,000	\$0
Total:	\$10,000	Total:	\$6,000

The total SHPN family Out-of-Pocket Limit has been met. For the remainder of the calendar year, any additional Covered Health Services submitted by this family under the SHPN option will be paid at 100% of Covered Charges (except for prescription drugs and other items obtained through Express Scripts). If any Member, however, seeks out-of-network care, the SHPN Out-of-Pocket Limits will not apply. You will need to meet the out-of-network Out-of-Pocket Limit for out-of-network care before this medical plan begins paying 100% of covered out-of-network charges under the medical plan.

BCBS PPO In-Network Example: An employee has a family of four Members. The BCBS PPO in-network Out-of-Pocket Limit is \$8,250. During the calendar year, the father and mother each incurred expenses (through Deductibles/Coinsurance) of \$3,000 and \$4,000, respectively. The first and second child incurred expenses (through Deductibles/Coinsurance) of \$3,000 each. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Limit by the claims administrator in the order of receipt of the claims. Then the second child incurred medical expenses, which are covered at 100% because the Out-of-Pocket Limit has been met. The individuals contribute to the In-network Out-of-Pocket Limit as follows:

BCBS PPO In-Network, Out-of-Pocket Limit Example			
	Expenses Incurred Through Deductible and Coinsurance	Individual Out-of-Pocket Limit	Allowable Contributions
Father	\$3,000	\$2,750	\$2,750
Mother	\$4,000	\$2,750	\$2,750
1st Child	\$3,000	\$2,750	\$2,750
2nd Child	\$3,000	\$2,750	\$0
Total:	\$13,000	Total:	\$8,250

The total in-network Out-of-Pocket Maximum for the family has been met. For the remainder of the calendar year, any additional Covered Health Services submitted by this family under the BCBS PPO in-network option will be paid at 100% of Covered Charges (except for prescription drugs and other items obtained through Express Scripts). If any Member, however, seeks out-of-network care, the BCBS PPO in-network Out-of-Pocket Limits will not apply. You will need to meet the out-of-network Out-of-Pocket Limit for out-of-network care before this medical plan begins paying 100% of covered out-of-network charges under the medical plan.

Cross-Application Example: An employee has a family of four Members. Early in the calendar year, the father and mother used SHPN providers each incurring expenses (through Deductibles/Coinsurance) of \$1,500 and \$4,000, respectively. The first and second child used SHPN providers each incurring expenses (through Deductibles/Coinsurance) of \$3,000 each. Subsequently, each Member incurred expenses via in-network providers. The father and mother each incurred \$5,000 of expenses. The first and second child incurred \$3,000 and \$7,000 of expenses, respectively. These expenses are determined to be Covered Charges and are applied to the Out-of-Pocket Limit by the claims administrator in the order of receipt of the claims.

The individuals contribute to the SHPN and In-network Out-of-Pocket Limit as follows:

SHPN/In-Network Cross Application Out-of-Pocket Maximum Example						
	SHPN			BCBS PPO		
	Expenses Incurred	Individual Limit	Allowable Contribution	Expenses Incurred	Individual Limit	Allowable Contribution
Father	\$1,500	\$2,000	\$2,000	\$5,000	\$2,750	\$750
Mother	\$4,000	\$2,000	\$2,000	\$5,000	\$2,750	\$750
1st Child	\$3,000	\$2,000	\$2,000	\$3,000	\$2,750	\$750
2nd Child	\$3,000	\$2,000	\$0	\$7,000	\$2,750	\$0
		Total:	\$6,000		Total:	\$2,250

The SHPN Out-of-Pocket Limit would have been met at \$6,000 and the BCBS PPO In-network Out-of-Pocket Maximum of \$8,250 has been met. For the remainder of the calendar year, any additional Covered Health Services submitted under the SHPN or BCBS PPO In-network option will be paid at 100% of Covered Charges (except for prescription drugs and other items obtained through Express Scripts). If any individual, however, seeks out-of-network care, the SHPN/BCBS PPO in-network Out-of-Pocket Limits will not apply. You will need to meet the out-of-network Out-of-Pocket Limit for out-of-network care before this Program begins paying 100% of covered Out-of-network charges under the medical plan.

The following table identifies what does and does not apply toward In-network and Out-of-network Out-of-Pocket Limits:

Features	Applies to the SHPN/BCBS PPO In-Network, Out-of-Pocket Limit?	Applies to the Out-of-Network, Out-of-Pocket Limit?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for non-covered healthcare services	No	No
Amounts of any reductions in benefits you incur by not following Prior Authorization requirements	No	No
Amounts you pay toward behavioral health services	Yes	Yes
Charges that exceed Covered Charges	Not applicable	No
Prescription drugs and other items obtained through Express Scripts	No	No

Prescription Drug Expenses Incurred Through Express Scripts

The prescription drug program has a separate Out-of-Pocket Limit, which is as follows:

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Limit	\$1,500 per person	None

Once a Covered Member has met his/her \$1,500 Prescription Drug Out-of-Pocket Limit (or \$5,950 per family) for the year, no additional co-insurance will be required for covered in-network prescription drugs for the remainder of the calendar year.

IMPORTANT: The Prescription Drug in-network Out-of-Pocket Limit does not apply to prescription drugs and other items purchased out-of-network, therefore, if you have met your In-network per person annual Out-of-Pocket Limit, and you purchase a prescription at an out-of-network retail pharmacy, you will be responsible for the applicable Coinsurance amount. Refer to [Section 7: Prescription Drug Program](#) for information on your prescription drug benefits.

Lifetime Maximums

The Sandia Total Health Program does not have any lifetime maximums, with the exception of the infertility benefit and travel and lodging as described in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#).

Infertility benefit: when you reach the \$30,000 lifetime maximum benefit, no additional reimbursement for any procedures incurred to treat infertility are payable. Other covered procedures related to family planning or reproduction (excluding infertility) may be payable. Refer to [Section 6: Covered Medical Plan Services / Limitations](#).

Travel and lodging: a combined overall maximum benefit of \$10,000 per covered recipient applies for all travel and lodging expenses reimbursed. This applies to all treatments during the entire period that the recipient is covered under this medical plan.

Section 5. Health Reimbursement Account

Health Reimbursement Account Administrator

To be eligible for HRA funding, you must be enrolled in the Sandia Total Health Medical Plan. ConnectYourCare will administer the HRA for BCBSNM. You can log onto their website to view all your HRA information and submit claims www.connectyourcare.com. ConnectYourCare customer service can be reached at 866-808-1444.

Health Reimbursement Account (HRA) Amounts

The Health Reimbursement Account (HRA) is an arrangement that will allow you to determine how some of your healthcare dollars are spent. Sandia will allocate an amount to the account that is based on:

- Your coverage and enrollment status (active, PreMedicare/single, family, etc.),
- Whether or not you and your covered spouse have completed a Health Assessment, through the Virgin Pulse Program website, and
- Whether or not you and your covered spouse have participated in the Virgin Pulse Incentive Program.

Annual Allocation of HRA Contributions

Coverage Category / Tier	Virgin Pulse Activity Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Total Possible HRA allocation ¹
Employee only	Maximum \$250 ²	\$250	\$0	\$500
Employee + spouse	Maximum \$500 ² (\$250 max each employee and spouse)	Maximum \$500 (\$250 each employee and spouse)	\$0	\$1,000
Employee + child(ren)	Maximum \$250 ²	\$500 (employee completes)	\$250	\$750
Employee + spouse +child(ren) ^(family)	Maximum \$500 ² (\$250 max each employee and spouse)	Maximum \$750 (both employee and spouse complete)	\$250	\$1,250

¹ This is the only amount that will be placed in your HRA during the calendar year and may be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses.

² Includes health action plan completion of employee and/or spouse for \$50 HRA contribution. PreMedicare retirees and their spouses, surviving spouses and dependents, and long term disability terminees are not eligible to participate in Virgin Pulse for HRA credit.

The HRA is entirely funded by Sandia and not taxable to you. You are not permitted to make any contribution to your HRA, whether on a pre-tax or after-tax basis. Your HRA is an “unfunded” account, and benefit dollars are payable solely from Sandia’s general assets.

Both the primary covered member and covered spouse are responsible for completing the health assessment to receive the full HRA contribution. Other covered dependents are not required to complete a health assessment.

Note: In order to receive HRA funding for each calendar year, **employees and their spouses** must complete their Health Assessments by **December 31** of the previous year. If the Health Assessment is completed by **November 30** of the previous year, HRA funds will be received by January 1.

PreMedicare retirees and their PreMedicare spouses, PreMedicare surviving spouses, and PreMedicare Long-term disability terminees and their spouses are required to complete their Health Assessment through the BCBSNM website from October 1 through September 30 in order to receive funding in the following year.

PreMedicare retirees (and their spouses) who were active employees for a portion of the current year and completed their Health Assessment(s) prior to retirement must complete a new Health Assessment in the current year through BCBSNM by September 30 in order to receive funding for the following year.

If you don’t spend all your HRA dollars in a calendar year, and you remain enrolled in the Sandia Total Health Program for the following year, any remaining HRA balance remains in the HRA for the next calendar year. The maximum balance in an HRA is capped at:

- \$1,500 for Primary Covered Member only coverage
- \$3,000 for Primary Covered Member plus spouse or plus child(ren)
- \$4,500 for family coverage

Events Resulting in Loss of HRA Funds

The maximum balance in an HRA at the beginning of any new year is capped at the amounts shown above. If you have an event that forces you to change coverage, your HRA balance will be adjusted accordingly at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member and spouse and get divorced. At the time of the divorce you have \$2,500 in your HRA. You may keep the HRA funds through the end of the calendar year, but the HRA balance will be reduced to \$1,500 beginning January 1 of the following calendar year, as that is the maximum balance for Primary Covered Member only coverage. For example, if you incur an Out-of-Pocket medical expense of \$2,000 in December that you file in January, you will only have \$1,500 in your HRA to cover that medical expense. **Note:** Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

If you terminate employment or lose coverage, you have 90 days to file claims for expenses incurred while you were covered under Sandia Total Health Plan. If you do not use your HRA funds and do not elect COBRA coverage, you forfeit any remaining HRA funds. Refer to [NTESS Health Benefits Plan for Employees Summary Plan Description](#) for information on continuing coverage under COBRA.

If you are a PreMedicare Retiree with no enrolled dependents, and you become Medicare-eligible, you have 90 days from date of Medicare eligibility to file claims from the date that the claims were incurred when you were enrolled in Sandia Total Health. Any HRA funds remaining after 90 days will be forfeited.

Note: If you are new to this plan at the start of the plan year and were previously enrolled in a different Sandia Total Health Medical plan, any HRA funds will not rollover until 90 days after the end of the previous calendar year. This ensures that your current carrier has access to your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires

Sandia will automatically make the full applicable Health Assessment portion of the HRA contribution (see [Annual Allocation of HRA Contributions](#)) for the calendar year in which you hire. To receive the Health Assessment portion of the HRA contribution for the next calendar year, you and your covered spouse must complete the Health Assessment by December 31 to receive funds by February 1 of the new calendar year, or by November 30 to receive funds by January 1 of the new calendar year.

Eligible Mid-Year Election Change Events

Sandia will automatically make the applicable HRA contribution for any employees, PreMedicare retirees, and/or their dependents that enroll in Sandia Total Health during the calendar year as a result of an eligible mid-year election change event. Examples include:

- If you have waived coverage because you have coverage elsewhere, and you lose that coverage and enroll in the Sandia Total Health Program within 31 calendar days of the loss of coverage, Sandia will contribute the applicable HRA contribution.
- If you get married mid-year, Sandia will contribute the applicable additional HRA contribution (\$250 to include spouse coverage or \$500 for family coverage) if you enroll your new eligible family members within 31 calendar days of marriage.

Open Enrollment Changes for Dual Sandians

If you switch Primary Covered Members during Open Enrollment, the total combined HRA will be assigned to the new Primary Covered Member on or around April 1.

If you have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and switch to Primary Covered Member only coverage, the HRA funds will remain with the original Primary Covered Member.

If you switch from Primary Covered Member or Primary Covered Member + child(ren) coverage to Primary Covered Member + Spouse or Primary Covered Member + Family coverage, the HRA funds will remain with the original Primary Covered Member.

What Healthcare Expenses are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses. For example, if you receive elective cosmetic surgery that is not eligible under Sandia Total Health, these claims are not eligible for payment by the HRA.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

How the HRA Works

Your HRA dollars are used to pay for qualified 213(d) expenses up to the amount allocated to your HRA. The complete HRA funds are available for use by any of your covered family members and are not apportioned on a per person basis. For example, if there is \$750 in available HRA funds and a claim is submitted for one Member in the amount of \$750, and the Member has an SHPN Deductible of \$500 or \$750 in-network Deductible. \$500 would be used to cover the SHPN Deductible leaving a balance of \$250 in available HRA funds or the full HRA funds of \$750 will be used to cover the in-network Deductible portion of this first claim.

HRA Example 1

Year 1:

You complete a Health Assessment and you have single coverage at the beginning of the year. Sandia allocates \$250 to your HRA. During the course of the year, you incur \$150 in Covered Charges. Your annual SHPN Deductible is \$500 or your in-network Deductible is \$750, and the entire \$150 of Covered Charges you incurred is subject to the Deductible. Your HRA is used to cover the \$150 expense that is applied to the Deductible amount.

Year 1 HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$150)</u>
Year 1 HRA Ending Balance	\$100

Your HRA balance is sufficient to cover the entire \$150 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid by the HRA. For year one, you have no Out-of-Pocket costs.

You have \$100 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 2:

You complete a Health Assessment for this year and have earned additional \$100 through the Virgin Pulse incentive, and you have single coverage at the beginning of the year. Sandia

allocates \$250 to your HRA. You start the year with a balance of \$450 (\$100 from the previous year plus \$250 from the current year for your HA plus \$100 from Virgin Pulse. During the course of the year, you incur \$100 in Covered Charges. The entire \$100 of Covered Charges you incurred is subject to the Deductible. Your HRA is used to cover the \$100 expense that is applied to your Deductible amount.

Year 1 HRA Carryover Balance	\$100
Plus Year 2 Health Assessment	\$250
<u>Plus Virgin Pulse</u>	<u>\$100</u>
Year 2 Beginning Balance	\$450
<u>Less HRA payment</u>	<u>(-\$100)</u>
Year 2 HRA Ending Balance	\$350

Your HRA is sufficient to cover the entire \$100 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year two, you have no Out-of-Pocket costs.

You have \$350 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Year 3:

You complete a Health Assessment for this year and you have earned additional \$250 through the Virgin Pulse incentive, and you have single coverage at the beginning of the year. Sandia allocates \$250 to your HRA for each completed task. You start the year with a balance of \$850 (\$350 from the previous year plus \$250 from the current year for your HA plus \$250 from Virgin Pulse). During the course of the year, you incur \$3,000 in Covered Charges. Your HRA is used to cover the \$500 Deductible for the SHPN as well as the Coinsurance of \$250 (\$3,000 less \$500 (Deductible) less \$250 (10% Coinsurance of \$2500)).

HRA Carryover Balance	\$350
Plus Year 3 Health Assessment	\$250
Plus Virgin Pulse	<u>\$250</u>
Year 3 Beginning Balance	\$850
<u>Less HRA payment</u>	<u>(-\$750)</u>
Year 3 HRA Ending Balance	\$100

Your HRA is sufficient to cover the entire \$3,000 of your annual healthcare costs. This means that the entire amount that was subject to the Deductible has been paid. For year three, you have no Out-of-Pocket costs.

You have \$100 of unused funds in your HRA that will roll over to the next calendar year if you continue enrollment in the Sandia Total Health Program.

Note: For simplicity, pharmacy, dental, and vision expenses were not illustrated in the examples; however, these expenses can also be paid for with the HRA by using your ConnectYourCare debit card or by filing a manual claim with ConnectYourCare. Contact ConnectYourCare at 866-808-1444 for assistance.

HRA Example 2

You have enrolled yourself and your spouse and you have completed your Health Assessment for the upcoming calendar year but **your spouse** did not. You do **not** receive your full \$500 allotment. You only receive \$250. During the course of the year, you incur \$500 in Covered Charges. Your annual SHPN Deductible is \$500. \$500 of Covered Health Services is subject to the SHPN Deductible.

HRA Beginning Balance	\$250
<u>Less HRA payment</u>	<u>(-\$250)</u>
HRA Ending Balance	\$0

The HRA is used to reimburse \$250 of your annual healthcare costs. You had \$500 in costs; the first \$250 of the Deductible is paid by the HRA. This means that you must pay an additional \$250 to meet your annual SHPN Deductible.

There is no remaining balance to roll over to the next calendar year.

Using your HRA with the Medical Plan

Your HRA dollars are used automatically to pay providers for your Member portion for SHPN/in-network services under the medical plan unless you visit the CYC portal www.connectyourcare.com and turn off the auto-pay. The following is the process for using your HRA for an SHPN/in-network doctor's visit:

1. Present your BCBSNM Member ID card to your doctor's office staff.
2. Your doctor's office submits your claim to BCBSNM.
 - a. BCBSNM processes your claim and determines your Out-of-Pocket liability. BCBSNM adjudicates claim, sends the claim information each day to Connect Your Care (CYC), CYC then examines your HRA. If an HRA balance is available to cover the full claim, CYC will pay the provider directly from the balance – you pay nothing. If an HRA balance is available to pay only a portion of the claim, CYC will pay the provider directly that portion, and you are responsible to pay the remaining amount to the provider.
 - b. If a claim is either partially or entirely denied or out-of-network, it will be your responsibility to file the claim directly to CYC to validate if it is an eligible expense under your Sandia Total Health BCBSNM plan.
 - c. If a denied claim is appealed through BCBSNM and overturned to pay under the Sandia Total Health, this revised claim will be sent to CYC to automatically pay to your provider.

- d. If there are no HRA funds and there is a balance owed provider, BCBSNM sends you an Explanation of Benefits (EOB) form – you pay the provider.

Note: If you are enrolled in a Healthcare Flexible Spending Account (HCFSA), CYC will first pay the provider from your HCFSA funds. Once those funds are depleted, CYC will then pay from your HRA funds.

Tracking Your Claims Payments

To help you track claims payments, make healthcare choices, and reduce healthcare costs, BCBSNM's subcontractor ConnectYourCare (CYC) maintain a flexible array of online programs and tools for subscribers ages 18 and older. You are able to view the balances of both your Healthcare FSA (HCFSA) and Health Reimbursement Account (HRA) on the CYC employee portal. To get started, go to www.connectyourcare.com and register by setting up your username and login. On the portal you can check: your account balances, enter a new claim, view claims, submit receipts for expenses requiring substantiation, and view submitted claims status.

Claims Processing with a HCFSA and/or HRA

BCBSNM providers are asked not to collect a payment at the time of service. The provider will bill BCBSNM, and BCBSNM will adjudicate your claim and send your claim information to CYC to process from your HCFSA, if enrolled, and from your HRA. You will receive an Explanation of Benefits form from BCBSNM showing amounts owed to your provider. To view payments from your HCFSA and/or HRA, log-in to www.connectyourcare.com. When the bill is presented to BCBSNM, it will pay in the following order: BCBSNM will determine how much of the bill Sandia Total Health will pay and how much you will pay (Deductible and Coinsurance). Sandia Total Health will pay its portion. Your portion (if any) will be paid first from your HCFSA (if you are enrolled), second from your HRA, and third by you for any additional unpaid amounts.

An out-of-network provider may require payment at the time of service. In this case, you will need to submit your out-of-network claim manually to BCBSNM for processing. When BCBSNM process the out-of-network claim, you are responsible for submitting for reimbursement to CYC.

Note: You cannot be reimbursed from more than one tax-advantaged plan (e.g. HCFSA and HRA) for the same expense. If you receive excess reimbursement from your HCFSA as well as your HRA, contact CYC at 866-808-1444 for instructions on how to repay any excess funds.

IMPORTANT: When using a debit card to pay for HRA claims, there are certain claims which are not automatically substantiated and require additional documentation (receipts that indicate the date of service, the vendor, the nature of the service and cost). For unsubstantiated claims identified by the HRA administrator, you will receive 3 notifications requesting additional documentation. Following the 3rd notice, debit cards will be inactivated until claim receipt documentation is received. For any unsubstantiated claim expenses not validated at the

end of the plan year, the amount may be reflected as income on your form W2 and taxed accordingly.. Please remember to save all FSA and HRA claim receipts.

Medical Plan Expenses

When you or your covered family member seeks Covered Health Services under the medical plan, you must present your BCBSNM identification card.

An SHPN or in-network provider will file a claim with BCBSNM on your behalf. If the service requires the Deductible or Coinsurance, BCBSNM will process your claim and send the claim information to CYC to look to see if you have funds in your HCFSA (if you are enrolled) and then your HRA. If you do, CYC will pull your share of the cost of the service from your HCFSA first and then your HRA to **pay the provider** directly. If you see an **out-of-network provider**, you are responsible for filing the claim with BCBSNM and CYC for processing. Eligible 213(d) expenses will be paid first from your HCFSA (if elected) until depleted and then the HRA will pay.

If you do not want auto-pay you have the option to turn off your FSA and HRA accounts. When the auto-pay setting is turned off for your FSA and HRA accounts, you can “Click-to-Pay” the claims of your choice. This gives you the convenience of choosing how you want to spend your dollars. If you keep your FSA and HRA accounts to auto-pay, all claims for medical and non-medical 213(d) items will pay first from your FSA, if enrolled, and second from your HRA.

Note: You can keep track of the dollars in your HCFSA and HRA by going online to www.connectyourcare.com or by calling Customer Service toll-free at 866-808-1444.

Prescription Drugs and Other Items Covered Under the Drug Plan

When you or your covered family member needs to purchase a prescription or other item covered through the prescription drug program, you must present your Express Scripts identification card. If you have HCFSA or HRA funds available, you can pay the patient portion to the pharmacy using your CYC debit card. If you choose to not use your debit card you can file a manual claim with CYC for reimbursement from your HCFSA (if you are enrolled) and then your HRA, if any.

Direct Deposit

You can log into your account at www.connectyourcare.com and select direct deposit.

Health Assessment and Biometric Screenings

A Health Assessment is a confidential online questionnaire that asks you about your health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes. You will receive a personalized report of your health status and any health risks you may have now or possibly down the road, and how you can take steps to prevent or manage those risks. If you have no health risks, the report will make suggestions for improving or better managing your health and well-being.

When completing a Health Assessment, you will be asked to enter your cholesterol, glucose, height, weight, waist measurement, and blood pressure. You are strongly encouraged to obtain a biometric screening to input into the Health Assessment so that you have an accurate picture of your health risks.

Note: The Health Assessment data will be reviewed only in aggregate to determine the need for health management programs.

Health Assessment Process

Active employees and their spouses must complete a Health Assessment by logging into their [Virgin Pulse account](#). Health Assessments must be completed by November 30 of the current year to receive funding by January 1 of the following year or by December 31 of the current year for funding for the following year.

PreMedicare retirees, and their PreMedicare spouses, LTD Terminées and their spouses, and Surviving Spouses must complete the Health Assessment by logging into their Blue Access for Members (BAM) account via the BCBSNM Well on Target website, www.wellontarget.com, by September 30 for funding for the following year. If you do not have a BAM account, you can register by visiting bcbsnm.com/sandia.

PreMedicare retirees (and their spouses) who retired prior to September 30 of the current year and completed the Health Assessment(s) prior to retirement through Sandia will need to complete a new Health Assessment through BCBSNM by September 30 in order to receive funding.

Other covered dependents are not required to complete a Health Assessment and \$250 is auto-funded to the HRA account regardless of number of dependents.

COBRA participants and their spouses are not required to complete a Health Assessment and \$250 each is auto-funded to the HRA account. Other covered dependents are not required to complete a Health Assessment and \$250 is auto-funded to the HRA account regardless of number of dependents.

Biometric Screenings Process

Employees can get biometric screenings either at the Sandia Onsite Clinic (at no cost) or through their personal physicians.

To obtain the screenings through the Sandia Onsite Clinic, you may schedule an appointment by calling HR Customer Service at 505-844 4237, option 2 in New Mexico, or option 3 in California.

When you get a biometric screening, a trained technician takes your blood pressure and other measurements and draws blood for analysis. You may be asked if you want fasting or non-fasting lab tests. Fasting lab test results will typically include total cholesterol, HDL, LDL, triglycerides, and glucose. Non-fasting tests report only total cholesterol and HDL. Fasting labs yield the most comprehensive lab test results, but either option will provide what is needed for the Health Assessment.

Retirees are not eligible to use the Sandia Onsite Clinic and will need to get their biometric screenings through their primary care physicians.

Virgin Pulse Incentive Management Program

With Virgin Pulse, employees and their covered spouses may participate in healthy activities and get rewarded - with better health and with points! Participants simply track their activities with a *GoZone pedometer* or many other tracking devices and apps of your choice listed within the Virgin Pulse Program. Visit join.virginpulse.com/Sandia for more details.

Health Action Plan

Active employees and their covered spouses are responsible for completing a health action plan to each receive \$50 HRA contribution annually. Health action plans are available only for active employees through Employee Health Services by visiting healthactionplan.sandia.gov until September 30. Health action plans are available through BCBSNM for both active employees and covered spouses until November 30. Other covered dependents are not required to complete a health action plan.

Retirees, surviving spouses, and Long Term Disability Terminees, and their dependents, are not eligible for the Virgin Pulse Program. If you participated in the Virgin Pulse Program, as an employee, and retired at the beginning of a calendar year, you will **not** receive any HRA funds in the subsequent calendar year. However, if you participated as an employee and retire on or after January 1 of the subsequent calendar year, any Virgin Pulse that you earned in the previous year will be applied to your retiree account on January 1 (so long as you have no break in coverage) and you will be eligible to keep those funds.

Tools and Resources to Become a More Informed Consumer

In addition to the many resources listed in this Program Summary (such as the 24/7 Nurseline, MD Live Virtual Visits, and the Special Beginnings® Maternity Program), you can also access important tools and resources from BCBSNM, ConnectYourCare, and Express Scripts through their websites.

Blue Access for Members

Blue Access for Members (BAM), the Member portal, offers you information on your health and health plan in one convenient location. To register for BAM, go to bcbsnm.com/sandia and select Register Now in the BAM log-in box; with your BCBSNM ID card handy, follow the on-screen registration instructions. Create a user name and password for instant and secure access to your personal information. After logging in, from your personal home page you can:

- Check your claims, including payment status and amounts, and sort/print claim information
- Confirm who is covered under your plan
- Download and print various forms
- Locate a doctor or hospital in your plans' network using Integrated Provider Finder

- Research and estimate costs for common healthcare services with the Member Liability Estimator tool
- Request a new or replacement ID

ConnectYourCare

The ConnectYourCare web portal provides Members with account information and health education tools. After logging in at www.connectyourcare.com, you can:

- Get your account balances,
- View payment card charges,
- Enter a request for withdrawal,
- View claims information,
- Register for mobile alerts,
- Access communication center messages,
- View reimbursement schedule,
- Use consumer tools, and more.

Express Scripts Website

The Express Scripts Member website, www.express-scripts.com, provides information at your fingertips anywhere and anytime you have access to the Internet. Express-Scripts.com offers practical and personalized tools and information so you can get the most out of your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Program

You can also access the above information on the Express Scripts phone app from any smartphone. Simply enter Express-scripts.com into your smartphone browser or download the app by going to the Apple App Store, Android Market or Blackberry World.

Section 6. Covered Medical Plan Services / Limitations

The Sandia Total Health Program provides coverage for a wide range of healthcare services for you and any covered family members. This section outlines the medical plan benefits available under the Sandia Total Health Program. For information on your prescription drug benefits administered by Express Scripts, refer to [Section 7: Prescription Drug Program](#).

Program Highlights

The Sandia Total Health Program does not have any pre-existing condition limitations. This means, for example, that if you have a condition such as pregnancy or cancer before you begin coverage, you are not required to wait a specific amount of time before you are eligible for medical plan benefit coverage. If a health service is not listed in this section as a Covered Health Service, or listed [Section 8: What's Not Covered – Exclusions](#) as a specific exclusion, it may or may not be a Covered Health Service. Members and dependents may contact the Sandia BCBSNM Onsite Customer Advocate at 505-284-8669 and/or onsite in SNL-NM, Building 832. Members may also reach out to BCBSNM Customer Service at 877-498-7652 for information.

IMPORTANT: Covered Health Services are those health services and supplies that are:

- Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental illness, Chemical Dependency, or their symptoms
- Medically Necessary
- Included in this section (subject to limitations and conditions and exclusions as stated in this Program Summary)
- Provided to you and your covered family members, if the eligibility requirements are met as described in the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#)

Coverage Details

The following information provides detailed descriptions of the covered healthcare services. For information on what is excluded from coverage, refer to [Section 8: What's Not Covered – Exclusions](#).

Acupuncture Services

Acupuncture services are covered as follows:

- X-rays and other services provided by a licensed acupuncturist or doctor of oriental medicine, medical doctor, licensed chiropractor, or doctor of osteopathy (either in- or out-of-network) with no review by BCBSNM required

- A maximum paid benefit of \$750 for acupuncture treatment per calendar year, per Member. This maximum applies to in- and out-of-network acupuncture treatment combined.

Allergy Services

Services related to allergies are covered as follows:

- Office visits
- Allergy testing
- Allergy serum
- Allergy shots

Ambulance Services

Ambulance services provided by a licensed ambulance service are covered as follows:

Ground Ambulance Services

- For Emergency transportation to the nearest hospital where Emergency health services can be performed is paid at the in-network level of benefit
- Transportation from one facility to another is considered an Emergency when ordered by the treating physician
- If there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Sandia Total Health Program will cover the services as billed

Air Ambulance Services

IMPORTANT: Prior Authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

- Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy
- Transport by air ambulance to nearest facility able to provide Medically Necessary services is a Covered Health Service if your condition precludes your ability to travel by a nonmedical transport (once you have been stabilized and expected to be long term, BCBSNM would transport you to closest contracted facility near your home)
- If you are in line for a transplant and the transplant has been approved by BCBSNM and there are no commercial flights to the city in which the organ is available, the Sandia Total Health Program will cover the medical transport of the patient via air ambulance or jet (whichever is less expensive)

Auditory Integration Training

Auditory integration training services are covered if the results of the evaluation fall within one of the following guidelines:

- A difference of 20dB or more between the most sensitive and least sensitive frequencies;
- The presence of at least one peak or processes, or an air-bone gap of more than 15 dB; or
- Less than 6/11 frequencies perceived at the same intensity level

Behavioral Health Services

Behavioral health services are subject to reimbursement with demonstrated improvement as determined by BCBSNM.

IMPORTANT: Prior Authorization is required before receiving inpatient, Partial Hospitalization, Residential Treatment Center, Intensive Outpatient Programs, or psychological testing services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers Outpatient mental health and Chemical Dependency services as follows:

- Evaluations and assessments
- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Individual and group therapeutic services
- Intensive Outpatient therapy programs
- Crisis intervention
- Psychological testing, including neuropsychological testing

The Sandia Total Health Program covers inpatient, Partial Hospitalization, and Residential Treatment Facilities for mental health and Chemical Dependency services as follows:

- Services received on an inpatient or Partial Hospitalization basis in a hospital or an alternate facility that is licensed to provide mental health or Chemical Dependency treatment

- If you are admitted to a facility and do not meet inpatient criteria, the BCBSNM Behavioral Health Unit will review to determine whether you meet Partial Hospitalization criteria. If you do meet Partial Hospitalization criteria, only the cost for Partial Hospitalization in that area will be allowed, and you will be responsible for the remainder of the cost.
- Room and board in a semi-private room (a room with two or more beds)
- Two Partial Hospitalization days are counted as one 24-hour hospitalization day
- Services received in a Residential Treatment Facility as long as there are at least six hours of therapy provided every calendar day

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by the BCBSNM Behavioral Health Unit.

Types of services that are rendered as a medical service, such as laboratory or radiology, are paid under the medical benefits.

If there are multiple diagnoses, the Sandia Total Health Program will only pay for treatment of the diagnoses that are identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

The Sandia Total Health Program covers intensive behavioral therapies such as Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders (ASD); any treatments or other specialized services designed for ASD that are backed by credible research and demonstrate that the services or supplies have a measurable and beneficial health outcome and are not considered Experimental or Investigational or Unproven Services.

Cancer Services

Oncology services are covered as follows:

- Office visits
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services
- High-dose chemotherapy

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer.

Cancer clinical trials and related treatment and services may be eligible for coverage. While you are not required to receive treatment at a Blue Distinction Center, if you do select such a facility and it is more than 50 miles from your home, you may be eligible for the travel and lodging benefit described in [Section 3: Accessing Care](#). Facilities selected as Blue Distinction Centers feature:

- Multi-disciplinary team input, including sub-specialty trained teams for complex and rare cancers and demonstrated depth of expertise across cancer disciplines in medicine, surgery, radiation oncology, pathology and radiology
- Ongoing quality management and improvement programs for cancer care
- Ongoing commitment to using clinical data registries and providing access to appropriate clinical research for complex and rare cancers
- Sufficient volume of experience in treating rare and complex cancers such as:
 - Acute leukemia (inpatient/nonsurgical)
 - Bladder cancer
 - Bone cancer
 - Brain cancer – primary
 - Esophageal, gastric, liver pancreatic, and rectal cancers
 - Head and neck cancers
 - Ocular melanoma
 - Soft tissue sarcomas
 - Thyroid cancer – medullary or anaplastic

Note: While you can select any in-network or out-of-network provider/facility for your care, the Blue Distinction Centers for Complex and Rare Cancers® program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Cardiac Care and Pulmonary Rehabilitation

This Sandia Total Health Program covers Outpatient cardiac rehabilitation programs initiated within six months of a cardiac incident and Outpatient pulmonary rehabilitation services.

Chiropractic Services

Chiropractic services are covered as follows:

- X-rays and other services provided by a licensed chiropractor or doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist (either in- or out-of-network) with no review by BCBSNM required, except that physical therapy requires Prior Authorization or benefits may be reduced or denied
- A maximum paid benefit of \$750 for spinal manipulation treatment per calendar year, per Covered Member. This maximum applies to in- and out-of-network benefits combined.

Congenital Heart Disease

Congenital heart disease services that are covered include:

- Office visits
- Outpatient diagnostic testing
- Evaluation
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services
- Interventional cardiac catheterization (insertion of a tubular device into the heart)
- Fetal echocardiograms (examination, measurement, and diagnosis of the heart using ultrasound technology) and
- Approved fetal intervention

While you are not required to receive treatment at a Blue Distinction Center, if you do select such a facility and it is more than 50 miles from your home, you may be eligible for the travel and lodging benefit described earlier.

Note: While you can select any in-network or out-of-network provider/facility for your care, the Blue Distinction Centers for Cardiac Care® program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Dental Services

IMPORTANT: Prior Authorization is required before receiving dental services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers dental services due to Illness or Injury to sound, natural teeth, or Injury to the jaw as follows:

- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiation to the mouth, etc.)
- Oral surgery, if performed in a hospital because of a complicating medical condition that has been documented by the attending physician
- Anesthesia, hospital and/or ambulatory surgical center expenses for dental procedures when services must be provided in that setting due to disability or for young children as determined by the attending physician
- Dental implants, implant-related surgery, and associated crowns or prosthetics are covered in situations where:
 - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
 - Both functional and aesthetic, and
 - Not adequately treatable by conventional orthodontic therapy
- Dental services related to medical transplant procedures
- Initiation of immunosuppressive therapy
- Direct treatment of cancer
- Direct treatment of cleft palate
 - Orthodontic appliances and treatment based on medical necessity, and
 - Children under 19 years of age with congenital anomaly
- As a result of accidental Injury to sound, natural teeth and jaw
- Tooth loss occurs as a result of accidental Injury to a sound, natural tooth

Note: For services that are provided as a result of an accident, initial treatment must have been started within one year of Injury regardless of whether you were covered under a Sandia medical plan or another employer plan.

IMPORTANT: If you receive coverage under the Sandia Total Health Program for implants, crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Dental Care Program for coordination of benefits. If you receive coverage under the Dental Care Program for implants, crowns or other prostheses required as a result of implants, you cannot submit any remaining portion to the Sandia Total Health Program.

Diabetes Services/Device/Supplies

The Sandia Total Health Program covers diabetes services as follows:

- Outpatient self-management training and education
- Medical nutrition therapy services
- Medical eye examinations (dilated retinal examinations)
- Preventive foot care

The Sandia Total Health Program covers diabetes devices and supplies as follows:

- External Insulin pump that delivers insulin by continuous subcutaneous infusion for treating patients with diabetes. Disposal external insulin pumps are considered equivalent to standard insulin pumps. Insulin pump criteria:

1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND
 2. Inability to achieve adequate glycemic control with intensive insulin therapy using multiple daily injections (MDI) as evidenced by:
 - a. A1c>7% and/or
 - b. Frequent hypoglycemia and/or
 - c. Marked dawn phenomenon and/or
 - d. Marked glycemic variability (this may be related to lifestyle issues such as participation in athletics or frequent travel AND
 3. Demonstrated ability and motivation to monitor glucose frequently (at least four times daily), count carbohydrates, and adjust the insulin regime as needed to achieve glycemic control.
- Supplies for external insulin pump and continuous glucose monitoring system
 - Blood glucose meters, if you are diagnosed with diabetes Type I or Type II
 - Long-term continuous glucose monitoring system (greater than 72 hours) criteria:
 1. Type 1 diabetes or Type 2 diabetes requiring basal and bolus insulin AND
 2. Willingness to wear the rt-CGM device at least 60% of the time AND
 3. Have demonstrated the ability to perform self-monitoring blood glucose frequently and to adjust the diabetes regimen based on the data obtained with monitoring.

IMPORTANT: Prior Authorization is required (with the exception of blood glucose meters) before receiving. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied. For items with a purchase or cumulative rental value of \$1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and you must purchase or rent the device from the vendor BCBSNM identifies for in-network benefit level.

Dialysis

This medical Sandia Total Health Program covers the following services when received from a dialysis provider or when Prior Authorization has been approved by BCBSNM, when received in your home:

- Renal dialysis (hemodialysis)
- Continual ambulatory peritoneal dialysis (CAPD)
- Apheresis and plasmapheresis
- The cost of equipment rentals and supplies for home dialysis

Diagnostic Tests

Diagnostic tests are covered as follows:

- Laboratory and pathology tests
- X-ray and radiology services, ultrasound and imaging studies
- Computerized Tomography (CT) scans (Prior Authorization Required for cardiac CT scans)
- EKG, EEG, and other electronic diagnostic medical procedures
- Genetic testing (Prior Authorization Required)
- Echocardiograms
- Electroencephalograms
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Psychological testing (Prior Authorization Required)
- Position Emission Tomography (PET) scans (Prior Authorization Required)
- Sleep disorder studies
- Other diagnostic tests

Durable Medical Equipment (DME)

IMPORTANT: Prior Authorization is required before receiving services with a purchase or cumulative rental value of \$1,000 or more. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

Durable medical equipment is covered as follows:

- Ordered or provided by a physician for Outpatient use
- Used for medical purposes
- Not consumable or disposable
- Not of use to a person in the absence of an Illness, Injury, or disability
- Durable enough to withstand repeated use
- Appropriate for use in the home

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth for women who are lactating. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician.

IMPORTANT: For items with a purchase or cumulative rental value of \$1,000 or more, BCBSNM will decide if the equipment should be purchased or rented, and you must purchase or rent the DME from the vendor BCBSNM identifies to receive in-network benefit level.

Examples of DME include, but are not limited to:

- Wheelchairs
- Hospital beds
- Equipment for the treatment of chronic or acute respiratory failure or conditions
- Equipment to administer oxygen
- Orthotic appliances when custom manufactured or custom fitted to you
- Oxygen
- Orthopedic shoes:
 - Up to two pairs of custom-made orthopedic shoes per year when necessary due to illness such as diabetes, post-polio, or other such conditions
- Mastectomy bras
 - Up to two bras per calendar year following a mastectomy
- C-PAP machine
- Bilirubin lights
- Braces that stabilize an injured body part and braces to treat curvature of the spine
- Delivery pumps for tube feedings, including tubing and connectors
- Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball)

One educational training session will be allowed to learn how to operate the DME, if necessary. Additional sessions will be allowed if there is a change in equipment.

More than one piece of DME will be allowed if deemed Medically Necessary by BCBSNM (e.g., an oxygen tank in the home and a portable oxygen tank).

At BCBSNM's discretion, benefits are provided for the replacement of a type of durable medical equipment once every three years. If the purchased/owned DME is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the DME is at least three years old. The Sandia Total Health Program will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed the new purchase price, if the DME breaks or is otherwise irreparable as a result of normal use, or when a change in your medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc. for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

Emergency Care

IMPORTANT: If you have a Medical Emergency, go to the nearest hospital Emergency room. These facilities are open 24 hours a day, seven days a week.

Medical Emergency care worldwide is covered as follows:

- Emergency services obtained from an SHPN provider will be considered at the SHPN level of benefits.
- Emergency services obtained from an in-network provider will be considered at the in-network level of benefits.
- Emergency services obtained from an out-of-network provider (including those outside the United States) will be considered at the in-network level of benefits.
- If you are hospitalized in an out-of-network hospital, you will be transferred to an SHPN or in-network hospital when medically feasible, with any ground ambulance charges reimbursed at the in-network level of benefits. If you decline to be transferred, coverage will be provided under the out-of-network benefit level.

Follow-up care worldwide is covered as follows:

- Follow-up care that results from a Medical Emergency while on travel outside the United States will be covered at the out-of-network level of benefit for services from an out-of-network provider and at the in-network level of benefit for services from an in-network provider.
- Follow-up care that results from a Medical Emergency while on travel within the United States will be covered at the in-network level of benefits only if the place of care is not located within 30 miles of any in-network provider. Covered Charges for services that could have been received before leaving your state of residence or that could have been postponed safely until your return home are eligible for coverage at the out-of-network benefit level.

Note: If you are on Sandia-authorized business travel, you may be eligible to have follow-up care covered at the in-network level of benefits. Contact BCBSNM onsite representative at: 505-284-8669 for details.

What is Not an Emergency

The Emergency room should never be used because it seems easier for you or your family. You may have to wait to be seen for a very long time and the charges for Emergency room services are very expensive – even if you have only a small problem. Members who use an Emergency room when it is not necessary will be responsible for paying all Emergency room charges.

You should not go to the Emergency room for conditions such as (but not limited to) sore throat, earache, runny nose or cold, rash, and stomach ache. If you have one of these problems or any other condition that is not an emergency, call your doctor first. If you can't reach your doctor or the doctor's office is closed, call the BCBSNM 24/7 Nurseline at 800-973-6329, 24

hours a day/7 days a week. A nurse will help you decide what to do to get better on your own or where you should go to get the kind of care that you need. The nurse may tell you to go to your doctor or an Urgent Care Center.

Employee Assistance Program (EAP)

The Employee Assistance Program is administered by Magellan Health Services. Prior Authorization from Magellan is required by calling 800-424-0320.

IMPORTANT: Prior Authorization is not required for the initial visit. Continued visits require Prior Authorization. If Prior Authorization is not received, benefits may be denied.

The Sandia Total Health Program covers up to eight visits per calendar year, or for California employees, up to three visits every six months, at no cost to the employee for assessment, referral, and follow-up counseling for employees and their covered family members experiencing some impairment from personal concerns that adversely affects their day-to-day activities.

Note: Retirees, survivors, and LTD terminees and their covered dependents are not eligible for Employee Assistance benefits.

Eye Exam/Eyeglasses/Contact Lenses

The Sandia Total Health Program covers eye exams for non-refractive care due to Illness or Injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts. An initial pair of contact lenses or glasses when required due to the loss of a natural lens or cataract surgery is allowed.

Employees and their covered family members that are enrolled in the Sandia Vision Care Program are eligible to receive services related to refractive care under that program. Refer to the [Preventive Care](#) benefits in this section for information on vision screenings.

Family Planning

Family planning services are covered as follows:

- Sterilization procedures such as vasectomies and tubal ligations
- Medically Necessary ultrasounds and laparoscopies
- Family planning devices that are implanted or injected by the physician such as IUDs or Depo-Provera
- Reversals of prior sterilizations
- Surgical, nonsurgical, or drug-induced pregnancy termination
- Health services and associated expenses for elective or therapeutic abortion

Diaphragms and any other birth control obtained at a pharmacy are eligible for coverage under Express Scripts.

Genetic Testing

Note: Prior Authorization is required before receiving genetic testing services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

The Sandia Total Health Program covers Medically Necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care. Refer to [Section 8: What's Not Covered – Exclusions](#) for information on what is excluded under genetic testing/counseling.

Hearing Aids/Exam

Note: Prior Authorization is required before receiving hearing aid and hearing exam services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

The Sandia Total Health Program covers the initial hearing exam and purchase of hearing aid(s) if the hearing loss resulted from an Injury or an Illness. Refer to the [Preventive Care](#) benefits in this section for information on hearing screenings.

The Sandia Total Health Program will cover one (1) hearing aid per hearing-impaired ear every thirty-six (36) months for dependent children under the age of 21. This coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician.

Home Healthcare Services

Note: Pre authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

Covered Health Services are services that a home health agency provides if you are homebound due to the nature of your condition. Services must be:

- Ordered by a physician
- Provided by or supervised by a registered nurse in your home
- Not considered Custodial Care in nature
- Provided on a part-time, intermittent schedule when skilled home healthcare is required

Hospice Services

Note: Pre authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

Hospice care is covered as follows:

- Provided on an inpatient basis

- Provided in your home
- Physical, psychological, social, and spiritual care for the terminally ill person
- Short-term grief counseling for immediate family members

Benefits are available only when Hospice care is received from a licensed Hospice agency or hospital.

Infertility Services

In general, the Sandia Total Health Program pays benefits for infertility services and associated expenses for the diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a physician.

Note: Pre-authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

A maximum lifetime benefit of \$30,000 per Member is allowed for infertility treatments. This maximum is accumulated from any expenses related to infertility treatment paid following a confirmed diagnosis of infertility. Expenses for infertility services incurred without a diagnosis of infertility will not be reimbursed. There are limitations to eligible procedures (refer to [Section 8: What's Not Covered – Exclusions](#) for more information).

The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility. However, testing and treatments after a confirmed diagnosis of infertility will be applied to the \$30,000 lifetime maximum such as:

- Medically Necessary laparoscopies and ultrasounds
- Artificial insemination
- In Vitro Fertilization (IVF)
- Gamete intrafallopian transfers (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Embryo transplantation
- Laparoscopies for egg retrieval
- Purchase of sperm, if billed separately
- Limited donor expenses for egg donor (only the same charges that would be eligible to extract the egg from a covered employee are allowed for the donor; prescription medications taken by a donor are not allowable charges)
- Storing and preserving embryos for up to two years

Prescription Drugs for Infertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility. The cost of these drugs is not applied to the \$30,000 infertility maximum if received through the Prescription Drug Program.

If the prescription drug is provided by the physician and billed through the provider's office or facility charges, BCBSNM will review the charge to determine eligibility for reimbursement. If categorized as an infertility treatment, the charges will be applied to the \$30,000 maximum. These charges may also be applied to the appropriate Program Deductibles and Out-of-Pocket Maximums. Coverage for prescriptions for donors is not covered.

Injections in Physician's Office

Injections in a physician's office are covered as follows:

- SHPN/In-network:
 1. Allergy shots – you pay 10 / 20% of Covered Charges, after the Deductible
 2. Immunizations/vaccines – no cost to you as outlined under [Preventive Care](#)
 3. All other injections (e.g., cortisone, Depo-Provera, etc.) – 10 / 20% of Covered Charges, after the Deductible
- For out-of-network services, you pay 40% of Covered Charges, after the Deductible.

Inpatient Care

Note: Pre authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied.

Inpatient services in a hospital are covered as follows:

- Services and supplies received during an Inpatient Stay
- Room and board in a semi-private room (a room with two or more beds)
- Intensive care

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by BCBSNM.

Benefits for an Inpatient Stay in the hospital are available only when the Inpatient Stay is necessary to prevent, diagnose, or treat an Illness or Injury.

If you are admitted to a hospital on an Emergency basis that is not in the network and services are covered, in-network benefits will be paid until you are stabilized (SHPN level of benefits will be paid only if services are received from an SHPN provider). Once stabilized, you must be moved to a network hospital to continue in-network benefits. You may elect to remain in

the out-of-network hospital and receive out-of-network benefits, as long as BCBSNM confirms the treatment to be Medically Necessary.

Maternity Services

IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section. Notification to BCBSNM is required **ONLY** if your stay will be longer than 48 hours following a normal delivery or longer than 96 hours following a cesarean section. Hospital stays longer than those mentioned above require Prior Authorization. If Prior Authorization is not received, benefits may be reduced by \$300.

Maternity services are covered as follows:

- Initial visit to the physician to determine pregnancy status
- Pre-natal and post-natal visits
- Charges related to delivery
- Charges for newborn delivery services, paid as follows:
 1. Charges billed for well-baby care are paid under the newborn but at the mother's level of benefit, subject to her Deductible and Out-of-Pocket Limit (e.g., if mom has met her Out-of-Pocket Limit, well-baby charges will be reimbursed as if the newborn's Out-of-Pocket Limit was met as well)
 2. Charges billed for the newborn under any other non-well baby ICD-10 code are paid under the newborn and subject to the newborn's Deductible and Out-of-Pocket Limit

Note: The Sandia Total Health Program will pay for Covered Health Services for the newborn for the first 31 calendar days of life. This is regardless of the newborn's condition or whether you enroll the eligible child within the applicable time frame as referenced in the Sandia Health Benefits Plan for Employees Plan Summary Plan Description or the [Sandia Health Benefits Plan for Retirees Summary Plan Description](#) for continued coverage. If you submit enrollment paperwork after the 31st calendar day but before the 61st calendar day of the birth, the coverage effective date will not be retroactive. For example, if you submit enrollment paperwork on the 41st calendar day after birth, the Plan will cover the first 31 days and 41st day and beyond. The member will be responsible for any charges incurred between the 32nd and 40th day. This coverage does not apply to third-generation dependents.

The Sandia Total Health Program will pay for maternity services for you, your covered spouse, and your covered children.

Licensed birthing centers are covered to include charges from the birthing center, physician, midwife, surgeon, assistant surgeon (if Medically Necessary), and anesthesiologist. Benefits for birthing services rendered in the home will be paid according to the network status of the physician with whom the licensed nurse midwife is affiliated. If the licensed nurse midwife is

not affiliated with a physician and is not a part of the network, reimbursement will be paid on an out-of-network level. If you are admitted to a hospital, you must notify BCBSNM within the time frames indicated above.

Refer to [Preventive Care](#) for information on preventive services related to maternity.

Special Beginnings®

This is a maternity program that is completely voluntary and free to Members. The program can help you better understand and manage your pregnancy. You may enroll in the program within three months of becoming pregnant. When you enroll, you'll receive a questionnaire to find out if there may be any problems with your pregnancy to watch out for, information on nutrition, newborn care, and other topics helpful to new parents. You will also receive personal and private phone calls from an experienced nurse – all the way from pregnancy to six weeks after your child is born. To learn more or to enroll, call 888-421-7781.

Extended Stay Newborn Care

You must ensure that BCBSNM is called regarding the newborn's extended stay before the mother is discharged from the hospital. If you do not, benefits for the newborn's covered facility services will be reduced by \$300. The baby's services will be subject to a separate Deductible and Coinsurance and a separate Out-of-Pocket Limit.

Medical Supplies

Certain medical supplies are covered, to include, but not limited to:

- Ostomy supplies
- Up to 6 pair or 12 individual, Medically Necessary, surgical or compression stockings, per calendar year
- Aero chambers, aero chambers with masks or nebulizers (you can obtain these either under the medical benefits or the Prescription Drug Program but not both)
- Breast pumps, accessories, and supplies ([Refer to Women's Additional Preventive Services.](#))

Lancets, alcohol swabs, diagnostic testing agents, syringes, Novopen and insulin auto-injectors, and allergic Emergency kits can be obtained under the prescription drug benefits (refer to [Section 7: Prescription Drug Program](#)).

Nutritional Counseling

The Sandia Total Health Program covers certain services provided by a registered dietician in an individual session if you have a medical condition that requires a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Coronary artery disease
- Congestive heart failure

- Gout (a form of arthritis)
- Renal failure
- Phenylketonuria (a genetic disorder diagnosed at infancy)
- Hyperlipidemia (excess of fatty substances in the blood)

Diet counseling for adults at higher risk for chronic diseases is covered under the preventive benefits. Refer to [Preventive Care](#) in this section.

Obesity Surgery

Note: Prior Authorization is required before receiving these services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

Surgical treatment for morbid obesity when received on an inpatient basis provided all of the following are true:

- Body Mass Index (BMI) of 35 to 39.9 with one or more obesity related co-morbid medical conditions, OR
- BMI equal or greater than 40 and demonstration that dietary attempts at weight control have been ineffective and the individual is 18 years of age or older or has reached full expected skeletal growth. Documentation of a structured diet program includes physician or other healthcare provider notes and/or diet or weight logs from a structured weight loss program for a minimum of six months.

Note: While you can select any in-network or out-of-network provider/facility for your surgery, the Blue Distinction Centers for Bariatric Surgery[®] program can help you find the program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334 or visit their website at http://www.bcbsnm.com/sandia/providers/blue_distinction.html.

Office Visits

The following services provided in the physician's office are covered as follows:

- Consultations
- Second opinions
- Post-operative follow-up
- Services after hours and Emergency office visits (allowed separately)
- Office surgery
- Supplies dispensed by the provider
- Diagnostic tests
- Laboratory services

- Radiology services
- Chemotherapy
- Radiation therapy

Organ Transplants

IMPORTANT: Prior Authorization must be requested in writing from BCBSNM. Authorization must be obtained from BCBSNM before a pre-transplant evaluation is scheduled. A pre-transplant evaluation is not covered if Prior Authorization is not obtained from BCBSNM. If authorized, a BCBSNM case manager will be assigned to you (the transplant recipient candidate) and you must contact the case manager with the results of the evaluation. If you are approved as a transplant recipient candidate, you must ensure that Prior Authorization for the actual transplant is received. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

Benefits are available to the donor and the recipient when the recipient is covered under the Sandia Total Health Program. The transplant must be a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which the Program will pay include but are not limited to:

- Heart
- Heart/lung
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Liver/kidney
- Liver/intestinal
- Pancreas
- Intestinal
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants are Covered Health Services.

The search for bone marrow/stem cells from a donor who is not biologically related to the patient is a Covered Health Service. If a separate charge is made for a bone marrow/stem cell search, the Program will pay up to \$25,000 for all charges made in connection with the search.

Note: If you receive Prior Authorization, you can select any in-network or out-of-network provider/ facility for your transplant. The Blue Distinction Centers for Transplants® program can help you find the transplant program that meets your needs. For more information call BCBSNM Health Services at 800-325-8334.

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

- Facility charge
- Anesthesia
- Supplies related to the surgery
- Equipment related to the surgery

Benefits for professional fees are described under [Professional Fees for Surgical Procedures](#) in this section. Also, see the list of procedures in the [Prior Authorization Requirements for Medical Services](#) section that require Prior Authorization.

Prescription Drugs (other than those dispensed by Express Scripts)

Enteral nutrition/nutritional supplements/prescription drugs under this Sandia Total Health Program are covered under the medical plan as follows:

- Enteral nutrition/nutritional supplements for:
 - Diagnosis of dysphagia (difficulty swallowing)
 - As the sole source of nutrition
 - Genetic disorder of Phenylketonuria (PKU)
 - RH factor disorders
 - Terminal cancer
- Intravenous medications
- Medication that is dispensed and/or administered by a licensed facility or provider, such as a hospital, home healthcare agency, or physician's office, and the charges are included in the facility or provider bill.

Note: Medication obtained through a mail order service is not eligible for reimbursement under BCBSNM. It may be eligible for reimbursement under Express Scripts on an out-of-network basis.

You can receive coverage for intravenous medications, enteral nutrition or nutritional supplements through either BCBSNM or Express Scripts, but not both. Refer to [Section 7: Prescription Drug Program](#) for information on coverage of prescription drugs not mentioned above.

Preventive Care

Sandia's preventive care benefits are based on the recommendations of the U.S. Preventive Services Task Force (USPST), American Academy of Pediatrics, and national medical standards.

See [Section 7: Prescription Drug Program](#) for information about covered preventive medications.

Preventive care benefits are covered as described below.

IMPORTANT: In order to ensure that you receive the preventive care benefit, the service must be submitted with a preventive ICD-10 diagnostic code. If it is submitted with a non-preventive ICD-10 diagnostic code, the service may be reimbursed at the non-routine, diagnostic benefit level. It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither Sandia nor BCBSNM can direct the provider to bill a service in any particular way. The issue as to how it is billed is between you and your provider.

Well-Baby Care (ages 0-2 years)

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- Routine physical exams (including height and weight) at birth and at one, two, four, six, nine, 12, 15, 18, and 24 months
- Autism screening at 18 and 24 months
- Behavioral assessment as needed
- Congenital Hypothyroidism screening for newborns
- Development screening – surveillance throughout childhood as needed
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screenings as needed
- Hematocrit or hemoglobin screening as needed
- Hemoglobinopathies or sickle cell screening for newborns
- Lead screening as needed
- Phenylketonuria (PKU) screening in newborns
- Thyroid screening as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunizations/Vaccines/Flu Shot Services](#) section for information on these covered services.

Well-Child Care (ages 3-10 years)

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Behavioral assessment as needed
- Development screening – surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hearing screening as needed
- Hematocrit or hemoglobin screening as needed
- Lead screening as needed
- Obesity screening and counseling as needed
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunizations/Vaccines/Flu Shot Services](#) section for information on these covered services.

Well-Adolescent Care (ages 11-18 years)

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Alcohol and drug use assessment as needed
- Behavioral assessment as needed
- Chlamydia infection screening as needed

- Cervical dysplasia screening as needed for sexually active females
- Development screening – surveillance throughout childhood as needed
- Dyslipidemia screening for children at higher risk of lipid disorders
- Hematocrit or hemoglobin screening as needed
- HIV screening as needed for adolescents at higher risk
- Lead screening as needed
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening as needed (A screening does not include an eye exam, refraction, or other test to determine the amount and kind of correction needed.)

Refer to the [Immunizations/Vaccines/Flu Shot Services](#) section for information on these covered services.

Well-Adult Care (19 years of age and older)

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- One routine physical/annual exam (including height, weight, and body mass index measurements) is allowed each calendar year regardless of the date of the previous routine physical/annual exam, but no more frequently than one per calendar year. Allowable exams include routine preventive physicals, including annual exams and sports physicals.
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 74 who have ever smoked
- Alcohol misuse screening and counseling as needed
- Blood pressure screening as needed
- BRCA genetic counseling and testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Cervical cancer screening for sexually active women
- Chlamydia infection screening as needed
- Depression screening as needed

- Diet counseling for adults at higher risk for chronic disease
- Gonorrhea screening for women at higher risk
- HIV screening as needed for adults at higher risk
- Obesity screening and counseling as needed
- Rubella screening (once per lifetime)
- Sexually transmitted infection prevention counseling for adults at higher risk
- Syphilis screening as needed for adults at higher risk
- Tobacco use screening as needed and cessation interventions for tobacco users
- Well woman exam annually

Refer to [Immunizations/Vaccines/Flu Shot Services](#), [Laboratory Services](#), [Cancer Screening Services](#), and [Bone Density Testing](#) later in this section for information on these covered services.

Immunizations/Vaccines/Flu Shot Services

The Sandia Total Health Program will pay 100% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the Deductible, if done out-of-network for non-travel related immunizations, vaccines, and flu shots. Flu shots and some immunizations/vaccines are available at no cost to you at an in-network retail pharmacy. Immunizations for personal travel will pay 80% of the Eligible Expenses in-network and 60% of the Eligible Expenses, after the deductible.

IMPORTANT: Immunizations for Sandia-business-related travel must be given at the Sandia's onsite clinic; however, if Sandia's onsite clinic directs the employee to obtain immunizations offsite for Sandia-business-related travel, you will be reimbursed at 100% of the charge, regardless of whether you obtain the immunizations in- or out-of-network. Contact the BCBSNM Onsite Advocate at 505-284-8669 if this exception is required to ensure proper reimbursement.

Laboratory Services

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

- Complete blood count (CBC) with differential, which includes white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monocyte, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology.

- Complete urinalysis, which includes source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamous epithelial, calcium oxylate
- Complete metabolic profile, which includes sodium, potassium, chloride, CO2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt
- Diabetes screening, which includes a two-hour postprandial blood sugar and HbA1c
- Thyroid screening, which includes free T4 and TSH
- Lipid panel, which includes triglycerides, total cholesterol, HDL, and calculated LDL cholesterol

As ordered by the physician, you are entitled to one of each of the above category once every calendar year. If the physician orders one or more components within one of the above categories but not the complete set, and it is submitted with a preventive code, it will still be eligible for reimbursement under the preventive benefit.

Cancer Screening Services

The Sandia Total Health Program provides preventive care coverage at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Covered Health Services include:

Service	Allowed Frequency	Allowable Age
Pap Test	As needed	Age 11 and older
Prostrate Antigen Test	Annual	Upon turning 50
Mammogram*	Baseline/ Annual	Between ages 35-39 / upon turning 40
Fecal Occult Blood Test	Annual	Upon turning 50
Sigmoidoscopy**	Once every five years	Upon turning 50
Colonoscopy**	Once every ten years	Upon turning 50
Barium Enema**	Once every five years	Upon turning 50

* High-risk women with an immediate family history (mother or sister) of breast cancer are eligible for an annual mammogram upon turning 25. The mammogram preventive benefit also includes the computer-aided detection test. The preventive benefit also includes the charge by the provider for interpreting the test results.

**You are entitled to the following:

- A sigmoidoscopy once every five years, OR
- A colonoscopy once every 10 years, OR
- A sigmoidoscopy or colonoscopy under age 50 or more frequently if you have an immediate family history (mother, father, sister, brother only) of colorectal cancer or you have a personal history of colonic polyps. Polyp removal during a preventive colonoscopy will be covered under the preventive colonoscopy benefit.

**A barium enema once every five years in lieu of a colonoscopy or sigmoidoscopy

Note: From time to time, Sandia will sponsor mobile mammogram screenings at Sandia or in the community through this program. Screenings are available to Covered Members age 35 and above (or for high risk women as outlined above). In addition, the annual requirement is waived for these screenings.

Pregnancy-Related Preventive Care Services

The Sandia Total Health Program provides preventive care coverage for the following pregnancy-related services, on an as needed basis, at 100% of the Covered Charges for covered SHPN/in-network services and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

- Multiple marker screening between weeks 15 and 18 for pregnant women age 35 and older
- Serum alpha-fetoprotein between weeks 16 and 18 based on personal risk factors
- Chorionic villus sampling before week 13 or amniocentesis between weeks 15 and 18 in women who are 35 and older and at risk for passing on certain chromosomal disorders
- Hemoglobiopathy screening if at risk for passing on certain blood disorders
- Screening for gestational diabetes
- Screening for Group B strep between 35 and 37 weeks
- Anemia screening on a routine basis
- Bacteriuria urinary tract or other infection screening
- Hepatitis B screening at first prenatal visit
- Rh incompatibility screening and follow-up testing for women at higher risk
- Syphilis screening
- Tobacco use screening and counseling as needed

Women's Additional Preventive Services

New guidelines expanded on the coverage of women's preventive services without cost sharing, including:

- Human papillomavirus (HPV) DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- Human immunodeficiency virus (HIV) screening and counseling
- FDA-approved contraception methods (generic prescriptions)
- Breastfeeding support, supplies, and counseling
 - Breast pumps – The rental (but not to exceed the total cost) or purchase of manual, electric, and hospital-grade breast pumps, accessories, and supplies with a written prescription from a healthcare provider

- Interpersonal and domestic violence screening and counseling

Bone Density Testing

The Sandia Total Health Program provides preventive care coverage for bone density testing once every three years upon turning age 50 at 100% of the Covered Charges for covered SHPN/in-network services, and at 60% of the Covered Charges, after the Deductible, for covered out-of-network services.

Professional Fees for Surgical Procedures

The Sandia Total Health Program pays professional fees for surgical procedures and other medical care received from a physician in a hospital, Skilled Nursing Facility, inpatient rehabilitation facility, or Outpatient Surgery facility.

The Program will pay the following surgical expenses:

- Only one charge is allowed for the operating room and for anesthesia.
- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: When bilateral surgical procedures are performed by one or two surgeons, the Sandia Total Health Program will consider the first procedure at the full allowed amount, and the second procedure will be considered at half of the allowed amount of the listed surgical unit value
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Sandia Total Health Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure. Also, if procedure 11721 is billed in conjunction with 10056 and 10057, these will be reimbursed separately without bundling when billed with a medical diagnosis.

Prosthetic Devices/Appliances

The Sandia Total Health Program covers prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include:

- Artificial limbs
- Artificial eyes

- Breast prosthesis following a mastectomy as required by the Women’s Health and Cancer Rights Act of 1998, including mastectomy bras (see Durable Medical Equipment) and lymph edema stockings. There are no limitations on the number of prostheses and no time limitations from the date of the mastectomy. Refer to [Reconstructive Procedures](#) for more information.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a physician, or under a physician’s direction.

Benefits are provided for the replacement of each type of prosthetic device once every five calendar years. At BCBSNM’s discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if the device or appliance breaks, or is otherwise irreparable, or when a change in your medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part. If the prosthetic device or appliance is lost or stolen, the Sandia Total Health Program will not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

IMPORTANT: Prior Authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

The Sandia Total Health Program covers certain Reconstructive Procedures where a physical impairment exists and the expected outcome is a restored or improved physiological function for an organ or body part.

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that you may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person’s breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure and is not covered. Refer to [Section 8: What’s Not Covered – Exclusions](#) for more information.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy. Coverage is provided for all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Replacement of an existing breast implant is covered if the initial breast implant followed mastectomy.

Rehabilitation Services (Outpatient Therapies)

IMPORTANT: Prior Authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for more information. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

Outpatient rehabilitation services for the following types of therapy are covered:

- Physical
- Occupational
- Speech
- Pulmonary rehabilitation
- Cardiac and pulmonary rehabilitation

Rehabilitation services must be provided by a licensed therapy provider and be under the direction of a physician. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by BCBSNM. Maintenance therapy is not covered.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., are covered when performed by a licensed chiropractor, physical therapist, or physician.

Note: Speech, physical, and occupational therapies rendered for developmental disorders are covered only until the patient is at a Maintenance level of care as determined by BCBSNM.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

IMPORTANT: Prior Authorization is required before receiving services. Refer to the [Prior Authorization Requirements for Medical Services](#) section for requirements. If Prior Authorization is not received, benefits may be denied or reduced by \$300.

Facility services for an Inpatient Stay in a Skilled Nursing Facility or inpatient rehabilitation facility are covered. Benefits include:

- Services and supplies received during the Inpatient Stay
- Room and board in a semi-private room (a room with two or more beds)

Note: The Sandia Total Health Program will pay the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice as determined by BCBSNM.

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an Illness or Injury that would have otherwise required an Inpatient Stay in a hospital.

The intent of skilled nursing is to provide benefits if, as a result of an Injury or Illness, you require:

- An intensity of care less than that provided at a general acute hospital but greater than that available in a home setting
- A combination of skilled nursing, rehabilitation, and facility services

The Program does not pay benefits for custodial care, even if ordered by a physician.

Temporomandibular Joint (TMJ) Syndrome

The Sandia Total Health Program covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint, including splints, when provided by or under the direction of a physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology. Covered services may include orthodontic appliances and treatment, crowns, bridges, or dentures only if services are required because of an accidental Injury to Sound Natural Teeth involving the temporomandibular or craniomandibular joint.

Urgent Care

The Sandia Total Health Program will cover Urgent Care as follows:

- Urgent Care services obtained from an SHPN Urgent Care facility will be considered at the SHPN level of benefits.
- Urgent Care services obtained from an in-network Urgent Care facility will be considered at the in-network level of benefits.
- Urgent Care services obtained from an out-of-network Urgent Care facility within the United States will be considered at the out-of-network level of benefits.
- If you are traveling outside the United States, your claim will be processed at the in-network benefit level for Urgent Care.

Follow-up care is covered as follows:

- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefit if you receive care from an out-of-network provider.
- Follow-up care while traveling outside the United States will be covered at the in-network level of benefit if you receive care from an in-network provider.
- Follow-up care while traveling within the United States will be covered at the in-network level of benefits if the place of care is not located within 30 miles of any in-network provider.

Urgent Care is needed for sudden Illness or Injuries that are not life threatening and you can wait a day or more to receive care without putting your life or a body part in danger. If you need Urgent Care, you have a choice of taking any of the following steps to receive care:

- Call your doctor's office and tell them you need to see a doctor as soon as possible, but that there is no Emergency. If your doctor tells you to go to the Emergency room because he or she cannot see you right away and you do not believe you have an Emergency, call the 24/7 Nurseline toll-free at 800-973-6329 for advice, or utilize the

virtual visit benefit through the MD Live portal at mdlive.com/sandia. You will need your member ID number located on your BCBSNM insurance card to register your account. Services apply to the SHPN Deductible, Coinsurance, and out of pocket.

- Ask your doctor to recommend another provider if he/she is unable to see you within 24 hours.
- Visit the nearest Urgent Care Center, SHPN Provider, or in-network Provider, for in-network benefit.
- Visit any Urgent Care Center, out-of-network, for out-of-network benefit.

Note: If you are traveling within the United States and there are no SHPN or in-network facilities available within a 30-mile radius, your claim will be processed at the in-network benefit level.

Section 7. Prescription Drug Program

The Prescription Drug Program, although part of the Sandia Total Health Program, is administered separately by Express Scripts. For information on filing claims, claim denials, and appeals, refer to [Section 10: How to File a Claim](#) and [Section 11: How to File an Appeal](#).

IMPORTANT: All claims must be submitted within one year after the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated.

The following chart summarizes your Coinsurance responsibility as well as coverage for purchases under the Smart90 Retail & Mail-Order Program and the Express Scripts network and out-of-network retail pharmacies.

Express Scripts Smart90 Retail/Mail-Order Pharmacy (for maintenance prescription drugs)		Express Scripts Network Retail Pharmacies	Out-of-Network Retail Pharmacies
Refer to Specialty Drug Management Program for information on coverage for specialty drugs.			
Generic prescription drugs	Coinsurance of 20% of Walgreens Pharmacy/mail order discount price with a \$12.50 minimum and \$25 maximum for generic prescription drugs	Coinsurance of 20% of retail discount price with a \$5 minimum and \$10 maximum for generic prescription drugs	50% reimbursement
Preferred brand name prescription drugs (formulary)	Coinsurance of 30% of Walgreens Pharmacy/mail order discount price with a \$75 minimum and \$112.50 maximum for preferred brand name prescription drugs	Coinsurance of 30% of retail discount price with a \$30 minimum and \$45 maximum for preferred brand name prescription drugs	50% reimbursement
Non-preferred brand name prescription drugs (non-formulary)	Coinsurance of 40% of Walgreens Pharmacy/mail order discount price with a \$125 and \$187.50 maximum for non-preferred brand name prescription drugs	Coinsurance of 40% of retail discount price with a \$50 minimum and \$75 maximum for non-preferred brand name prescription drugs	50% reimbursement
Days' Supply	Maximum of 90-day supply	Maximum of 30-day supply	Maximum of 30-day supply File claims with Express Scripts
Out-of-Pocket Limit	Out-of-Pocket Limit is \$1,500 per person per year or \$5,950 per family). There is not an Out-of-Pocket limit for Out-of-Network prescription drugs or Smart90 eligible prescription drugs purchased outside of the program after two courtesy fills.		Out-of-Pocket Limit does not apply
If a multi-source generic drug is reclassified as a single-source brand name, the Coinsurance will change from 20% to 30% or 40% with the applicable minimum and maximum copays. Coinsurance does not apply to the Sandia Total Health Program medical Deductible and/or Out-of-Pocket Limit. Reimbursement for prescriptions purchased outside the United States will be reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.			

Eligibility

If you are eligible for coverage under the Sandia Total Health Program, then you are eligible for the Prescription Drug Program. If you have primary prescription drug coverage under another group healthcare plan or Medicare, you are not eligible to use the Mail-Order Program or purchase drugs from retail network pharmacies at the Coinsurance benefit.

Coordination of Benefits applies. If you or your dependent has primary prescription drug coverage elsewhere, file the claim first with the appropriate plan, and then file with Express Scripts, attaching a copy of the EOB. Express Scripts will allow 50% of the price submitted, with no days-supply limit, up to the amount you pay Out-of-Pocket.

Covered Prescriptions

IMPORTANT: FDA approval of a drug does not guarantee inclusion in the Prescription Drug Program. New drugs may be subject to review before being covered under the Prescription Drug Program or may be excluded based on program guidelines and policies.

Only licensed providers authorized to prescribe medications in the United States may issue your prescription(s). To be covered, the prescription must be considered Medically Necessary. Consideration of Medical Necessity occurs when a clinician's request falls outside standard criteria. Medical Necessity is a case-by-case assessment based upon substantiated justification as documented by the treating healthcare professional. It must be in accordance with standard medical practice and clinical appropriateness to include but not limited to off-label and non-indicated uses. The Prescription Drug Program covers the following categories of drugs:

- Federal Legend Drugs – A medicinal substance that bears the legend “Caution: Federal Law prohibits dispensing without a prescription”
- State Restricted Drugs – A medicinal substance that, by state law, may be dispensed by prescription only
- Compounded Medications – A compounded prescription in a customized dosage form that contains at least one federal legend drug. Contact Express Scripts before you fill your prescription to confirm if your compound is covered.
 - The U.S. Food and Drug Administration (FDA) defines a compound medication as one that requires a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription. Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online and paper claim submissions. All ingredients submitted with the compound prescription claim must be covered and at least one of the ingredients must require a physician's prescription for reimbursement.
 - Prescriptions containing certain ingredients (such as, over-the-counter (OTC) products, bulk powders, kits, solid dosage forms, and proprietary bases) when compounded for dispensing are **not** covered through the prescription benefit. Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.
- The following prescription devices/supplies:

- Insulin auto-injectors
- Lancet auto-injectors
- Glucagon auto-injectors
- Epi-Pens
- Aero-chambers, aero-chambers with masks, nebulizer masks (you may receive coverage under either the medical portion with BCBSNM or the Prescription Drug Program but not both)

Note: Medicare covers lancets and test strips. Continuous Glucose Monitoring Systems (CGMS), Insulin Pumps, and supplies for CGMS and Insulin Pumps are not covered under the Prescription Drug Program. Please refer to [Section 3: Accessing Care](#) for coverage information.

- The following over-the-counter (OTC) medications/supplies:
 - Nutritional supplements (requires Prior Authorization)
 - Insulin and Diabetic Supplies – Supplies, including lancets, alcohol swabs, ketone test-strips (both blood and urine), and syringes, can be purchased at the appropriate Coinsurance level, in-network with a prescription, or in-network without a prescription by paying the full price and submitting the claim to Express Scripts for reimbursement. (You will be reimbursed at the appropriate Coinsurance level.) The Mail-Order Program is also available for insulin and diabetic supplies purchased with a prescription.

Note: Medicare covers lancets and test strips.

Note: The Prescription Drug Program covers immunizations obtained and/or administered at retail network pharmacies at no cost to you. In addition, Express Scripts maintains a program in which certified pharmacists within the U.S. are licensed to prescribe and administer certain vaccinations. To inquire about this Program, contact Express Scripts at 877-817-1440.

Covered Preventive Medications

The Sandia Total Health Program will pay 100% of the cost at a retail network pharmacy for the following medications:

- One aspirin per day (generic only) to prevent cardiovascular disease for age 45 to as follows:
 - Aspirin 81 mg to 325 mg
 - Aspirin chew 81 mg to 325 mg
 - Aspirin delayed release 81 mg to 325 mg
 - Aspirin dispersible tab 81 mg
- One aspirin per day (generic only) to prevent Preeclampsia for women age 55 or younger as follows:

- Aspirin 81 mg
- Aspirin chew 81 mg
- Aspirin delayed release 81 mg
- Aspirin dispersible tab 81 mg
- Bowel Preparation Agents
 - Generic only
 - Adults; ≥ 50 and ≤ 75 years of age.
 - Fill Limit: 2 prescriptions per 365 days
- Oral fluoride supplementation (prescription only) for children between the age of six months and five years whose primary water source is deficient in fluoride as follows:
 - Sodium fluoride tab 0.5 mg
 - Sodium fluoride chew tab 0.25 mg to 0.5 mg
 - Sodium fluoride solution
- Folic acid tab 0.4 mg and 0.8 mg (one per day) for women age 50 or younger who may become pregnant
- Gardasil – 3 doses over a 6-month period – females age 9 to 26
- Hepatitis A and B vaccine
- Influenza vaccine
- Meningococcal vaccine
- Pneumococcal vaccine – as needed
- Low/moderate dose of a statin (generic only) to prevent cardiovascular disease for adults age 40-75 as follows:
 - Atorvastatin 10 – 20mg
 - Fluvastatin IR and XL 20 - 80mg
 - Lovastatin 10 - 40mg
 - Pravastatin 10 - 80mg
 - Simvastatin 5 - 40mg
 - Rosuvastatin 5 - 10mg
- Tobacco cessation products for ages 18 and older as follows:
 - Nicotrol Inhaler and Nasal Spray (refer to Prescriptions with Quantity Limits)
 - Zyban
 - Chantix
 - Nicotine patches

- Varicella (chicken pox)
- Vitamin D
 - Generic OTC & Generic RX
 - Age: ≥ 65
 - Single entity vitamin D2 or D3 containing 1,000IU or less per dosage form.
 - Combination products that also contain calcium (combination of two agents only for the combinations)
- Women's Contraceptives:
 - Generic
 - Single source (SS)
 - Multiple source (MS)
 - Dispense as Written per Physician (DAW1)
 - Brand single source
 - Barrier contraceptive method – diaphragms/cervical caps
 - Hormonal contraceptive methods – oral, transdermal, intravaginal Injectable Hormonal contraceptives
 - Emergency contraceptive method – e.g. Plan B and Ella
 - Implantable medications – e.g. Implanon
 - Intrauterine contraceptives – e.g. Mirena, Skyla
- Zoster (Zostavax) / shingles – adults age 60 and older
- Shingrix / shingles – adults age 50 and older

Note: All preventive medications require a prescription, whether they are over the counter or not.

National Preferred Formulary

The Sandia Total Health Program utilizes the Express Scripts' National Preferred Formulary. Preferred Drugs are selected according to safety, efficacy (whether the drug works for the indicated purpose), therapeutic merit (how appropriate the drug is for the treatment of a particular condition), current standard of practice, and cost. Non-Preferred drugs are also on the Formulary, but at a higher cost sharing tier. Drugs that are excluded from Formulary are not covered by the prescription drug program unless approved through a Formulary exception process managed by Express Scripts. If approved through the process, the non-preferred copay applies.

The Formulary is the same for both the Mail-Order Pharmacy and the retail network pharmacies and is comprehensive for all major categories of acute and maintenance medications. To find out the Formulary status of a drug, you can either call Express Scripts at

877-817-1440 or look on the web at www.express-scripts.com (enter the member ID# from your ID card, your date of birth and “Sandia” in the Rx Group Number field).

If, for some reason, you are unable to take any of the preferred alternatives, you, your pharmacist or your physician can initiate an exception request by contacting Express Scripts directly and requesting a Prior Authorization (PA) for the medication. Refer to the information below for PA information. Express Scripts will contact your doctor and request the information necessary for a non-preferred brand name drug. Express Scripts will review the letter and make the decision as to whether you will be able to receive the non-preferred drug for the preferred brand name Coinsurance amount, or excluded drugs at the non-preferred Coinsurance amount.

Prescriptions Requiring Prior Authorization

A Prior Authorization (PA) is a clinical program that ensures appropriate use of prescription medications. You, your pharmacist or your physician can initiate a PA for the medication by contacting Express Scripts Prior Authorization department directly at 800-417-8164 and requesting a PA for the medication. Medications subject to a PA require a clinical review and pre-approval from the Express Scripts Prior Authorization Team before they can qualify for coverage under this Program. Medications requiring Prior Authorization are subject to change. Therefore, if you have questions about a particular drug, please contact Express Scripts customer service at 877-817-1440.

Prescriptions Subject to Step Therapy Program

Step Therapy (Step)

Step Therapy is a program in which certain drug classes are organized in a set of “steps”, first line drugs used first prior to second line alternatives. Drug classes included in this program are subject to change. If you have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440.

Prescriptions Subject to Quantity Limits

Drug Quantity Management (DQM) is a program in your pharmacy benefit that’s designed to make the use of prescription drugs safer and more affordable. It provides you with medicines you need for your good health and the health of your family, while making sure you receive them in the amount – or quantity – considered safe. Medications included in this program are subject to change. Therefore, if you have questions about a particular drug or this program, please contact Express Scripts customer service at 877-817-1440.

- Sleep Agents: 15 tabs/30 days or 45 tabs/90 days (limitation is waived if prescribed by a Sleep Specialist as deemed by Express Scripts)
- Erectile Dysfunction: 8 tabs/30 days or 24/90 days
- Revatio/Adcirca: 93 in 31 days
- Tussionex: 120 ML in 30 days

- Nicotrol Nasal Spray: 3 kits/30 days
- Tamiflu: 10 caps per year

Smart90 Retail Program

Express Scripts partners with Walgreens Pharmacy to offer the Smart90 Program. Smart90 is a program for members taking long-term prescriptions to receive them in a 90-day supply at lower cost than 30-day supply.

Smart90 offers two options to receive medications:

- Prescriptions may be filled and delivered by Express Scripts Pharmacy Home Delivery, or
- Filled by a participating Walgreens Pharmacy

You can request that your provider submit an e-prescription for a 90-day supply of medication with exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Walgreens Pharmacy or Express Scripts Pharmacy at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in network pharmacy of your choice for pickup. Smart90 provides two courtesy months of refills at a 30-day supply.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scripts at 877-817-1440 or fax it to 888-327-9791. Prescriptions preferred to be filled at Walgreens Pharmacy can be called in our hand carried to any local Walgreens Pharmacy.

See the Mail Order Program below on more information about Home Delivery from Express Scripts Pharmacy.

Note: For medications that are eligible for the Smart90 Program, you will receive two courtesy months of refills at the retail coinsurance amount at any In-Network retail pharmacy.

However, if you do not elect one of the above options, you will be responsible to pay 100% of the cost of the prescription(s) afterwards. These costs do not apply to the prescription drugs Out-of-Pocket limit. The Smart90 Retail Program does not apply to controlled substances, narcotic medications, or specialty medications dispensed through Accredo Pharmacy. See [Specialty Drug Management Program](#) for more details.

Mail Service Program

Express Scripts partners with Express Scripts Pharmacy to offer a Mail Service Benefit. Express Scripts Pharmacy is a licensed pharmacy specializing in filling prescription drug orders for maintenance prescriptions. Maintenance prescription drugs are those taken routinely over a long period of time for an ongoing medical condition. Let your physician know that you are planning to use the Mail Service Program and request a 90-day prescription (with up to three refills). Verify that the prescription specifies the exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills.

Registered pharmacist and technicians are available 24 hours a day, seven days a week, at 877-817-1440, to answer medication-related questions. Prescriptions are delivered to your home. (You are not responsible for shipping and handling fees unless you request special shipping arrangements.) To obtain a maintenance prescription through the Mail Service Program, you pay the appropriate Coinsurance for each prescription up to a 90-day supply.

If you send in a prescription through the Mail Service Program and Express Scripts Mail Service does not carry the medication or if it is out of stock and Express Scripts Mail Service does not anticipate getting the medication in a timely manner, you will be able to receive a 90-day supply at a retail network pharmacy for the applicable mail-order Coinsurance. Contact Express Scripts at 877-817-1440 for assistance.

Note: If you are a patient in a nursing home that does not accept mail-order prescriptions, contact Express Scripts to make arrangements to receive up to a 90-day supply of medication at a retail network pharmacy for the applicable mail-order Coinsurance. You must provide proof of residency in a nursing home.

Steps for Ordering and Receiving Mail Order Prescriptions (other than Specialty Medications)

You can request that your provider submit an e-prescription for a 90-day supply of medication with exact information for daily dosage, strength, quantity (e.g., number of pills, inhalers, tubes), and number of refills to Express Scripts Pharmacy at the time of the appointment, if electronic prescribing is available. If medication is needed right away, request a second prescription of a 30-day supply be sent to a local in network pharmacy of your choice for pickup.

If e-prescribing is not available, providers may also call in the prescriptions to Express Scripts at 877-817-1440 or fax it to 888-327-9791.

If you would prefer to mail in your original prescription, follow the steps for ordering and receiving below:

Step	Action	
1	Forms	Obtain an Express Scripts Mail Service Registration & Prescription Order Form from the Sandia website or www.express-scripts.com .
2	Ordering Original Prescriptions	<p>Complete the Express Scripts Mail Service Registration & Prescription Order Form. Attach your original written prescription (with your Member Identification number and address written on the back). Make sure your physician has written the prescription for a 90-day supply with applicable refills. Enclose the required Coinsurance using a check or money order or complete the credit card section on the form. Mail all to Express Scripts Mail Service, PO Box 66568, St. Louis, MO 63166-9819. Your physician may also call in the prescription to Express Scripts at 877-817-1440 or fax it to 888-327-9791.</p> <p>Note: If you need medication immediately, ask your doctor for two (2) separate prescriptions – one for a 30-day supply to be filled at a network retail pharmacy, and one to be filled by mail service. Wait and send in your mail service prescription two weeks after you fill your prescription at the retail network pharmacy to avoid any delays with your mail service prescription.</p>

Step	Action	
3	Delivery	Expect delivery to your home by first-class mail. A physical street address is needed. There are additional charges for requesting express shipping.
4	Refills	<p>Refilling a mail service order prescription can be done by phone, mail, or through the web. It is recommended that you order three weeks in advance of your current mail service prescription running out.</p> <p>Refill-by-Phone: Call 877-817-1440 to order refills. You may use the automated refill system 24 hours a day. Customer service representatives are available Monday through Sunday 24/7.</p> <p>Refill-by-Fax: Have your physician contact Express Scripts for the Fax Order Form. The physician (not you) must fax the number on the form. Note: Schedule II prescriptions cannot be faxed.</p> <p>Refill-by-Mail: Complete the Prescription Order Form (attached to the bottom of your customer receipt), making sure you adhere the refill label provided or write the prescription number in the space provided. Mail in the self-addressed, postage-required envelope.</p> <p>Refill through the Web: Go to www.express-scripts.com. Log on to this site. On the left-hand side of your screen, select "Order Prescriptions". From there, follow the instructions to place your refill order. You will need to use one of the accepted credit cards for payment.</p> <p>Refill-by-Mobile App: Download the free app, log in with your www.express-scripts.com username and password. If you haven't yet registered with www.express-scripts.com, you can create a username and password right from the app – and use the same username and password to access the website.</p>

Brand-To-Generic Substitution

Every prescription drug has two names: the trademark, or brand name; and the chemical or generic name. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength, and quality.

Example: Tetracycline is the generic name for a widely used antibiotic. Achromycin is the brand name.

Many drugs are available in generic form. Generic drugs offer substantial cost savings over brand names; therefore, the Mail-Service Program has a generic substitution component. Unless your doctor has specified that the prescription be dispensed as written, your prescription will be filled with the least expensive acceptable generic equivalent when available and permissible by law. If you receive a generic medication in place of the brand name medication, and you want the brand name medication, you will need to obtain a new prescription stating "no substitution" or "dispense as written" and resubmit it along with the required Coinsurance.

Exception: This provision does not apply to brand name drugs that do not have an FDA A- or AB-rated generic equivalent available.

Retail Pharmacies

This section does not apply to Smart90 Retail Program eligible medications filled at a participating Walgreens Pharmacy.

Retail pharmacies are available if you need immediate, short-term prescription medications, and/or prescription medications that cannot be shipped through the mail.

Using the Network Retail Pharmacies

Express Scripts has contracted with specific retail pharmacies across the nation that will provide prescriptions to Sandia at discounted rates. These pharmacies are known as retail network pharmacies. To locate the pharmacy nearest you, call Express Scripts at 877-817-1440 or visit www.express-scripts.com.

To obtain a medication through a retail network pharmacy, you will need a written prescription from your physician. Present the prescription and your Express Scripts ID card to the pharmacist. The card is required to identify that you are covered under the Program in order to remit the appropriate Coinsurance.

If you request a prescription to be filled in a retail network pharmacy for more than a 30-day supply, the pharmacist will fill only 30 days for the appropriate Coinsurance of 20%, 30%, or 40% and hold the rest as refills. When you need a refill, return to the pharmacy, pay another Coinsurance amount, and receive another maximum 30-day supply (or up to the amount prescribed by the physician).

Using the Out-of-Network Retail Pharmacies

If you choose to purchase a prescription through an out-of-network pharmacy, you will be reimbursed 50% of the cost for up to a 30-day supply. Any amounts over a 30-day supply will be denied. Refer to [Section 10: How to File a Claim](#).

Specialty Drug Management Program

Specialty medications must be purchased through the Express Scripts' Specialty Pharmacy, Accredo Specialty Pharmacy (Accredo), in order to be eligible for coverage. Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions such as cancer, hepatitis C, multiple sclerosis, rheumatoid arthritis, etc. To find out if your prescription falls into this category, call Express Scripts at 877-817-1440.

Under this Program, your prescription will be limited to a 30-day supply and will be subject to the retail Coinsurance level of benefits. Any amounts over a 30-day supply will be denied. There is no additional cost to you above your required Coinsurance. In addition to your medication, you will also receive the necessary supplies for administration such as alcohol swabs and syringes at no additional cost. The Specialty Pharmacy is staffed by experienced pharmacists who are specially trained in complex health conditions and the latest therapies to provide support, counseling and assistance with medication management.

Steps for Ordering and Receiving Specialty Prescriptions through Accredo:

Step	Action	
1	Ordering Original Prescriptions	Your physician submits the prescription for you directly to the Accredo Specialty Pharmacy by e-prescription, fax, telephone or mail. Your information is entered into the ordering system and a pharmacist reviews it for completeness and contacts your physician, if necessary.
2	Payment	Accredo will call you to confirm your insurance and to let you know what the Coinsurance will be. You must have a credit card on file. Accredo will bill the card you have on file for the applicable Coinsurance.
3	Delivery	Accredo will call you to schedule a delivery date. Expect delivery to your home (unless you made alternative shipping arrangements with Accredo directly) via overnight mail. Most orders ship via UPS or Federal Express for next day delivery.
4	Refills	Once enrolled, Accredo will call you prior to your next dose. However, if you have not received a phone call, please contact Accredo to avoid any disruption in your therapy. Accredo will confirm your information and schedule a delivery date at your convenience.

Section 8. What’s Not Covered – Exclusions

Although the Sandia Total Health Program provides benefits for a wide range of Covered Health Services, there are specific conditions or circumstances for which the Sandia Total Health Program will not provide benefit payments. In general, any expense that is primarily for your convenience or comfort or that of your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program, refer to [Section 7: Prescription Drug Program](#).

You should be aware of these exclusions that include, but are not limited to, items in the following table.

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the claims administrator determines are Covered Charges, as defined Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount you pay as a result of failure to contact BCBSNM for Prior Authorization, including unauthorized care Employee Assistance Program services when you do not obtain Prior Authorization from Magellan Health Services Charges incurred for services rendered that are not within the scope of a provider’s licensure Charges for missed appointments
Ambulance	Non-Emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Behavioral health services that are considered to be at maintenance level of care. Family therapy, including marriage counseling and bereavement counseling. Family therapy, marriage counseling, and bereavement counseling are covered for employees and their dependents only through the Employee Assistance Program. Conduct disturbances unless related to a coexisting condition or diagnosis otherwise covered. Educational, vocational, and/or recreational services as Outpatient procedures. Biofeedback for treatment of diagnosed medical conditions. Treatment for insomnia, other sleep disorders, dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under the medical portion of this Program). Treatment that is determined by BCBSNM to be for your personal growth or enrichment. Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a BCBS PPO network provider for mental health or Chemical Dependency

Exclusions	Examples
Behavioral Health Services, cont.	<p>Services to treat conditions that are identified by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a mental disorder.</p> <p>Sex transformations.</p> <p>Any services or supplies that are not Medically Necessary.</p> <p>Custodial Care.</p> <p>Pastoral counseling.</p> <p>Developmental Care.</p> <p>Treatment for caffeine or tobacco addictions, withdrawal, or dependence.</p> <p>Aversion therapies.</p> <p>Treatment for codependency.</p> <p>Non-abstinence-based or nutritionally-based treatment for Chemical Dependency.</p> <p>Services, supplies, or treatments that are covered under the medical part of this Program.</p> <p>Treatment or consultations provided via telephone.</p> <p>Services, treatments, or supplies provided as a result of a Worker's Compensation law or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide UBH with a lien against the claim for damages or relief in a form and manner satisfactory to UBH.</p> <p>Non-organic erectile dysfunction (psychosexual dysfunction).</p> <p>Treatment for conduct and impulse control disorders, personality disorders, paraphilias (unusual sexual urges), and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by BCBSNM.</p> <p>Services or supplies that:</p> <ul style="list-style-type: none"> • Are considered Unproven, Experimental or Investigational drugs, devices, treatments, or procedures • Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments, or procedures <p>Wilderness programs, boot camp-type programs, work camp-type programs, or recreational-type programs.</p> <p>Services or supplies that are primarily for your education, training, or development of skills needed to cope with an Injury or Illness.</p> <p>Chemical Dependency benefits for Class II dependents.</p>
Biofeedback	Biofeedback is not a Covered Health Service
Congenital Heart Disease	CHD services other than as listed under Coverage Details .
Dental Procedures	<p>Dental procedures are not covered under this Sandia Total Health Program except for Injuries to Sound, Natural Teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of Injury.</p> <p>Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.</p>
Drugs	In addition to the clinical guideline limitation imposed by Express Scripts (see Section 7: Prescription Drug Program – Covered Prescriptions), the Program

Exclusions	Examples
Drugs, cont.	<p>excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following:</p> <p>Over-the-counter medications unless specifically included</p> <p>Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses</p> <p>Contraceptive foams, jellies, and ointments</p> <p>Drugs labeled “Caution: Limited by Federal Law to Investigational use or Experimental drugs”</p> <ul style="list-style-type: none"> • Experimental drugs are defined as “a therapy that has not been or is not scientifically validated with respect to safety and efficacy.” • Investigational drugs are defined as “those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce.” <p>Glucose tablets</p> <p>Drugs used for cosmetic purposes</p> <p>Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation</p> <p>Refills of prescriptions in excess of the number specified by the physician</p> <p>Refills dispensed after one year from the date of order by the physician</p> <p>Prescription Drugs purchased for those who are ineligible for coverage under the Sandia Total Health Program</p> <p>Prescription Drugs taken by a donor who is not insured under the Sandia Total Health Program</p> <p>Medicine not Medically Necessary for the treatment of a disease or an Injury</p> <p>The following are excluded by the Prescription Drug Program but may be covered by BCBSNM if Medically Necessary:</p> <ul style="list-style-type: none"> • Ostomy supplies • Blood glucose meters • Implantable birth control devices such IUDs • Allergy serum • External Insulin pumps and supplies • Continuous glucose monitoring systems and supplies <p>Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home healthcare agency, or physician’s office, and the charges are included in the facility or provider bill to BCBSNM</p>
Equipment	<p>Exercise equipment (e.g., exercycles, weights, etc.)</p> <p>Hearing aids for hearing loss except for dependents up to age 21 and for Illness or Injury (see benefit under hearing aids for more details)</p> <p>Braces prescribed to prevent injuries while you are participating in athletic activities</p> <p>Household items, including, but not limited to</p> <ul style="list-style-type: none"> • Air cleaners and/or humidifiers • Bathing apparatus • Scales or calorie counters

Exclusions	Examples
Equipment, cont.	<ul style="list-style-type: none"> • Blood pressure kits • Water beds Personal items, including, but not limited to <ul style="list-style-type: none"> • Support hose, except Medically Necessary surgical or compression stockings • Foam cushions • Pajamas Equipment rental fees above the purchase price, with the exception of oxygen equipment
Experimental or Investigative or Unproven Treatment	Experimental or Investigational Services or Unproven Services, unless the Sandia Total Health Program has agreed to cover them in Section 6: Covered Medical Plan Services/Limitations . Note: This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices, or pharmacological regimens are the only available treatment option for your condition. Note: This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Genetic Testing/ Counseling	Experimental or Investigational or Unproven genetic testing is not covered. In addition, genetic counseling, including service for evaluation and explaining the implications of genetic or inherited disease, whether provided by physicians or non-physician health professionals, for the interpretation of family and medical histories to assess the risk of disease occurrence or recurrence, and for assisting in making treatment decisions based upon the risk of disease occurrence or recurrence is not covered. Refer to Genetic Testing and Preventive Care for covered services.
Hospital Fees	Expenses incurred in any federal hospital, unless you are legally obligated to pay Hospital room and board charges in excess of the semi-private room rate
Hospital Fees, cont.	unless Medically Necessary and approved by BCBSNM In-hospital personal charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a Covered Health Service
Infertility, Reproductive, and Family Planning	Purchase of eggs Services related to or provided to anonymous donors Services provided by a doula (labor aide) Storing and preserving sperm Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a Covered Member for a donor are allowed Expenses incurred by surrogate mothers
Infertility, Reproductive, and Family Planning, cont.	Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes Over-the-counter medications for birth control/prevention Parenting, pre-natal, or birthing classes
Miscellaneous	Eye exams except as outlined under Section 6: Covered Medical Plan Services/Limitations

Exclusions	Examples
Miscellaneous, cont.	<p>Eyeglasses or contact lenses prescribed, except as outlined under Section 6: Covered Medical Plan Services/Limitations. Contact lenses are not considered a prosthetic device.</p> <p>Modifications to vehicles and houses for wheelchair access</p> <p>Health club memberships and programs or spa treatments</p> <p>Treatment or services</p> <ul style="list-style-type: none"> • Incurred when the patient was not covered under this Sandia Total Health Program even if the medical condition being treated began before the date your coverage under the Sandia Total Health Program ends • For Illness or Injury resulting from your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., you did not start the act of aggression) • For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law • While on active military duty • That are reimbursable through any public program other than Medicare or through no-fault automobile insurance • Charges in connection with surgical procedures for sex changes • Charges for blood or blood plasma that is replaced by or for the patient <p>Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under this Sandia Total Health Program</p> <p>Christian Science practitioners and facilities</p> <p>Food of any kind unless it is the only source of nutrition, there is a diagnosis of dysphagia (difficulty swallowing), in case of terminal cancer, or in cases of PKU or RH factor.</p> <p>Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless listed as covered</p> <p>Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes</p> <p>Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Section 7: Prescription Drug Program</p> <p>Herbs and over-the-counter medications except as specifically allowed under the Sandia Total Health Program</p> <p>Charges prohibited by federal anti-kickback or self-referral statutes</p> <p>Chelation therapy, except to treat heavy metal poisoning</p> <p>Diagnostic tests that are:</p> <ul style="list-style-type: none"> • Delivered in other than a physician’s office or healthcare facility • Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests <p>Domiciliary care</p> <p>Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded.</p> <p>Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when:</p>

Exclusions	Examples
Miscellaneous, cont.	<p>Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration</p> <ul style="list-style-type: none"> • Conducted for purposes of medical research • Related to judicial or administrative proceedings or orders or • Required to obtain or maintain a license of any type <p>Private duty nursing received on an inpatient basis Respite care Rest cures Storage of blood, umbilical cord, or other material for use in a Covered Health Service, except if needed for an imminent surgery</p>
Not a Covered Health Service and/ or Not Medically Necessary	<p>These health services, including services, supplies which are not:</p> <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing or treating Illness, Injury, mental illness, Chemical Dependency or their symptoms; • Consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; • For the convenience of the covered person, physician, facility or any other person; • Included in Section 6: Covered Medical Plan Services/Limitations; • Provided to a Member who meets the Sandia Total Health Program’s eligibility requirements; and <p>Not identified in general Program exclusions.</p>
Old Claims	Claims received one year after the date charges are incurred
Physical Appearance	<p>Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage required by the Women’s Health and Cancer Right’s Act of 1998.</p> <p>Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include:</p> <ul style="list-style-type: none"> • Repair of defects that result from surgery for which you were paid benefits under the Program • Reconstructive (not cosmetic) repair of a congenital defect that materially corrects a bodily malfunction. <p>Note: For the purposes of this exclusion, poor self-image or emotional or psychological distress does not constitute a bodily malfunction.</p> <p>Liposuction Pharmacological regimens Nutritional procedures or treatments Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures) Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity (except that certain surgical procedures may be covered if the patient meets criteria listed in Section 6 and has the procedure Prior Authorization approval by BCBSNM)</p>

Exclusions	Examples
Physical Appearance, cont.	Wigs regardless of the reason for hair loss Treatments for hair loss
Providers	<p>Services:</p> <ul style="list-style-type: none"> • Performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider • Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in your medical care <ul style="list-style-type: none"> ○ Prior to ordering the service or ○ After the service is received <p>This exclusion does not apply to mammography testing.</p>
Services, supplies, therapy, or treatments	<p>Charges that are:</p> <ul style="list-style-type: none"> • Custodial in nature • Otherwise free of charge to you • Furnished under an alternative medical plan provided by Sandia • For aromatherapy or rolfing (holistic tissue massage) • For Developmental Care after a maintenance level of care has been reached • For Maintenance Care • For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage • Educational therapy when not Medically Necessary • Educational testing • Smoking-cessation programs unless covered under Section 6: Covered Medical Plan Services / Limitations • Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy
Surgical and nonsurgical treatment for obesity	<p>Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by BCBSNM/BCBSNM Behavioral Health</p> <p>The following treatments for obesity:</p> <ul style="list-style-type: none"> • Non-surgical treatment, even if for morbid obesity, and <p>Surgical operations for the correction of morbid obesity determined by BCBSNM not to be Medically Necessary and/or not meeting the criteria outlined in Section 6.</p>
Transplants	Health services for organ and tissue transplants except as identified under Organ Transplants in Section 6 unless BCBSNM determines the transplant to be appropriate according to BCBSNM's transplant guidelines.

Exclusions	Examples
Transplants, cont.	<p>Determined by BCBSNM to be Unproven procedures for the involved diagnoses</p> <p>Not consistent with the diagnosis of the condition</p> <p>Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available)</p> <p>Donor costs for organ or tissue transplantation to another person unless the recipient is covered under the Sandia Total Health Program</p>
Transportation	<p>Non-Emergency ambulance services are not covered.</p> <p>Transportation, except ground ambulance and air ambulance services as outlined in Section 6, Covered Medical Plan Services/Limitations and as described in Section 3 if the Member uses a Blue Distinction Center for Specialty Care Programs for a covered transplant, cardiac care admission, or cancer treatment</p>
Travel	<p>Travel or transportation expenses, regardless of personal or business travel, even if ordered by a physician, except as identified under Blue Distinction Center for Specialty Care Programs in Section 3: Accessing Care.</p> <p>Medical repatriation outside of the United States regardless of personal or business travel</p>

Section 9. Coordination of Benefits (COB)

Coordination of Benefits (COB) is the provision that allows families with different employer group health plan coverage to receive up to 100% coverage for Covered Health Services. Under COB your health plan as the employee provides primary coverage for you and your spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more information on COB policy and rules for determining which plan provides primary coverage.

This medical Sandia Total Health Program contains a COB provision so that the benefits paid or provided by all employer group plans are not more than the total allowable expenses under this medical Sandia Total Health Program. The medical Sandia Total Health Program will not pay more than 100% of the cost of the medical treatment, nor will it pay for treatment or services not covered under this medical Sandia Total Health Program.

"Covered Health Expense" means a healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the group health plans covering the person. An expense or an expense for a Covered Health Service that is not covered by any of the group health plans is not a Covered Health Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not a Covered Health Expense. The following are additional examples of expenses or Services that are not Covered Health Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.
- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.
- If a person is covered by two or more group health plans that provide benefits or Services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not a Covered Health Expense.
- If a person is covered by one group health plan that calculates its benefits or services on the basis of usual and customary fees and another group health plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a payment arrangement and if the provider's contract permits, the negotiated fee or

payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not a Covered Health Expense. Examples of these provisions are second surgical opinions, precertification of admissions, etc.

Refer to Section 3 of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more information on “Special Rules for Covered Medicare-Primary Members” and “Provision for Covered Members with End-Stage Renal Disease (ESRD).”

Beginning January 1 of every year or if you are a new enrollee, you are required to provide an update to BCBSNM on whether any of your covered family members have other insurance. This notification is also required if your family member enrolls in another medical plan during the year. If you do not provide this information to BCBSNM, your covered family members’ claims may be denied. You may update your other insurance information by calling BCBSNM at 877-498-7652.

Refer to [Section 7: Prescription Drug Program](#) for information on eligibility to use the Prescription Drug Program, as well as how COB works, if your covered family member has other insurance coverage.

Section 10. How to File a Claim

This section provides an overview of how to file a claim and the receipt of benefit payments under the Sandia Total Health Program.

Filing an Initial Claim

Refer to Section 8 of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for claim definitions, timeframes for disposition of Urgent Care, pre-service, concurrent care, and post-service claims, and the information that you are entitled to receive from the claims administrator upon processing of your claim.

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. If you need assistance in filing a claim, call BCBSNM Customer Service at 877-498-7652 for medical claims or Express Scripts at 877-817-1440.

SHPN/In-Network Claims Processing

Generally, when you seek services through an SHPN or in-network provider, the provider verifies eligibility and submits the claims directly to the claims administrator for processing. There are generally no claim forms necessary to obtain SHPN/ in-network benefits. Refer to [Section 5: Health Reimbursement Account \(HRA\)](#) for information on payments from your HRA and [Section 7: Prescription Drug Program](#).

[Section 7: Prescription Drug Program](#) for information on how to use network retail and mail order pharmacy benefits.

Out-of-Network Claims Processing

When you seek services through an out-of-network provider, you will need to submit the claim for reimbursement. The provider may not verify eligibility. It is your responsibility to verify you are eligible for benefits by either calling the claims administrator or going to bcbsnm.com/sandia or www.express-scripts.com. You can obtain claim forms from the claims administrator or at hr.sandia.gov.

Submit the claim form to the claims administrator immediately after the expense is incurred but no later than one year from the date of service. Completion and submission of the claim form does not guarantee eligibility for benefits.

Process for Out-of-Network Claims Processing for Medical Care

To obtain reimbursement for medical care, attach the itemized medical bill to the claim form and mail it to the address shown on the claim form or the address on your BCBSNM Member ID card. Itemized medical bills should include:

- Patient's full name and relationship to the Primary Covered Member
- Primary Covered Member's name and BCBSNM identification number and group number
- Date and place of treatment or purchase
- Diagnosis
- Type of service provided
- Amount charged
- Name and address of provider and tax identification number, if available
- If other insurance is primary, the EOB (from the primary insurer) attached to your claim form

When covered services are received from nonparticipating providers, mail the forms and itemized bills to the local Blue Cross Blue Shield Plan in the state where services were received. If a provider will not file a claim for you, ask for an itemized bill and complete the claim form the same way that you would for services received from any other nonparticipating provider. Send claims to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, New Mexico 87125-7630

If services are received from a Non-preferred Provider in New Mexico, payments are usually made to the Primary Covered Member (or to the applicable alternate payee when a Qualified Medical Child Support Order is in effect). The check will be attached to an EOB that explains BCBSNM's payment. In these cases, you are responsible for arranging payment to the provider and for paying any amounts greater than Covered Charges plus Deductibles, Coinsurance, any penalty amounts, and non-covered expenses.

If a Qualified Medical Child Support Order (QMCSO) or a properly completed National Medical Support Notice (NMSN) is in effect and conforms to ERISA requirements, the QMCSO or NMSN provisions will be followed. Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for more information.

Medicaid — Payment of benefits for Members eligible for Medicaid is made to the appropriate state agency or to the provider when required by law.

Outside the United States, U.S. Virgin Islands, Jamaica, Puerto Rico, or Canada — for covered **inpatient hospital** services received outside the United States (including Puerto

Rico, Jamaica, and the U.S. Virgin Islands) and Canada, show your Plan ID card issued by BCBSNM. BCBSNM participates in a claims payment program with the Blue Cross and Blue Shield Association. If the hospital has an agreement with the Association, the hospital files the claim for you to the appropriate Blue Cross Plan. Payment is made to the hospital by that Plan, and then BCBSNM reimburses the other Plan.

You will need to pay up front for care received from a **doctor, a participating Outpatient hospital, and/or a nonparticipating hospital**. Then, complete an international claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The International Claim Form is available from BCBSNM, the BlueCard Worldwide Service Center, or online at <https://www.bluecardworldwide.com>.

The BlueCard Worldwide International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico, Jamaica and the U.S. Virgin Islands. The International Claim Form must be completed for each patient in full and accompanied by fully itemized bills. It is not necessary for you to provide an English translation or convert currency.

Since the claim cannot be returned, please be sure to keep photocopies of all bills and supporting documentation for your personal records. The Member should submit an International Claim Form, attach itemized bills, and mail to BlueCard Worldwide at the address below. BlueCard Worldwide will then translate the information, if necessary, and convert the charges to United States dollars. They also will contact BCBSNM for benefit information in order to process the claim. Once the claim is finalized, an Explanation of Benefits will be mailed to the Primary Covered Member and payment, if applicable, will be made to the subscriber via wire transfer or check. Mail international claims to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

Process for Out-of-Network Claims Processing for Prescription Drugs

If you have a prescription filled by an out-of-network pharmacy, complete a Direct Member Reimbursement Form, attach pharmacy receipts, and send your claim to Express Scripts.

Benefits Payments

Refer to the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for general information on benefits payments.

BCBSNM will pay benefits directly to you for all out-of-network providers.

Express Scripts will pay benefits to the provider when you use a network or mail order pharmacy. If you use an out-of-network provider, Express Scripts will pay any applicable benefits to you.

Note: The person who receives a service is ultimately responsible for payment of services received from the providers.

BCBSNM will send you an Explanation of Benefits (EOB) each time they process a claim for you or a covered family member. The EOB statement is a summary of your recent claims, plus remaining balances for your HRA, Deductibles, and Out-of-Pocket Maximums in one easy-to-read format. You may also view your EOBs online through BlueAccess for Members at bcbsnm.com/sandia.

If any claims are denied in whole or in part, you will still receive an Explanation of Benefits (EOB), which will include the reason for the denial or partial payment. The EOB will let you know if there is any portion of the bill you need to pay.

If you would rather track claims online, you may elect to discontinue receipt of paper EOBs at bcbsnm.com/sandia. You may also elect to continue to receive EOBs by making the appropriate elections online or by calling BCBSNM Customer Service at 877-498-7652.

For eligible prescription drug claims processed through a Direct Member Reimbursement Form, you will receive an EOB with the payment from Express Scripts.

Pricing of Non-Contracted Provider Claims

The BCBSNM Covered Charge for some Covered Health Services received from Non-preferred Providers is the lesser of the provider's billed charges or the BCBSNM "Non-contracting Allowable Amount." The BCBSNM Non-contracting Allowable Amount is based on the Medicare Allowable amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS). The Medicare Allowable is determined for a service covered under this medical plan using information on each specific claim and, based on place of treatment and date of service, is multiplied by an "adjustment factor" to calculate the BCBSNM Non-contracting Allowable Amount. The adjustment factors for non-Emergency services are 100% of the base Medicare Allowable.

Certain categories of claims for Covered Health Services from Non-preferred Providers are excluded from this non-contracted provider pricing method. These include:

- Services for which a Medicare Allowable cannot be determined based on the information submitted on the claim (in such cases, the Covered Charge is 50% of the billed charge)
- Home health claims (the Covered Charge is 50% of the billed charge)
- Services administered and priced by any subcontractor of BCBSNM or by the Blue Cross Blue Shield Association
- Claims paid by Medicare as primary coverage and submitted to this medical plan for secondary payment
- Ground ambulance claims (for which the state's Public Regulatory Commission sets fares)

BlueCard Program

BCBSNM hereby informs you that other Blue Cross and Blue Shield Plans outside of New Mexico (“Host Blue”) may have contracts with certain providers in their service areas. Under BlueCard, when you receive Covered Health Services outside of New Mexico from a Host Blue contracting provider that does not have a contract with BCBSNM, the amount you pay for Covered Health Services is calculated on the lower of:

- The billed charges for your Covered Health Services, or
- The negotiated price that Host Blue passes on to BCBSNM.

Often, this “negotiated price” is a simple discount that reflects the actual price that Host Blue pays. Sometimes, it is an estimated price that takes into account special arrangements Host Blue has with an individual provider or a group of providers. Such arrangements may include settlements, withholds, non-claims transactions, and/or other types of variable payments. The “negotiated price” may also be an average price based on a discount that results in expected average savings (after taking into account the same special arrangements used to obtain an estimated price). Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted from time to time to correct for over- or under-estimation of past prices. However, the amount used by BCBSNM to calculate your share of the billed amount is considered a final price.

Laws in a small number of states may require Host Blue to 1) use another method for, or 2) add a surcharge to, your liability calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSNM would calculate your liability for any covered services according to the applicable state law in effect when you received care. Surcharges are not your responsibility.

Independent Contractors

The relationship between BCBSNM and its network providers is that of independent contractors; physicians and other providers are not agents or employees of BCBSNM, and BCBSNM and its employees are not employees or agents of any network provider. BCBSNM will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any network provider. The relationship between BCBSNM and Sandia National Labs is that of independent contractors; the employer is not an agent or employee of BCBSNM, and BCBSNM and its employees are not employees or agents of Sandia National Labs.

Sending Notices

All notices to you are considered to be sent to and received by you when deposited in the United States mail with first-class postage prepaid and addressed to the Primary Covered Member at the latest address on BCBSNM membership records or to the employer.

Membership Records

BCBSNM will keep membership records, and Sandia will periodically forward information to BCBSNM to administer the benefits of this medical plan. You can inspect all records concerning your membership in this medical plan during normal business hours given reasonable advance notice.

Disclosure and Release of Information

BCBSNM will only disclose information as permitted or required under state and federal law.

Research Fees

BCBSNM reserves the right to charge you an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in the Explanations of Benefits, letters, or other forms.

Recovery of Excess Payment

The claims administrator has the right at any time to recover any amount paid by the Sandia Total Health Program for Covered Charges in excess of the amount that should have been paid under the provisions. Payments may be recovered from you, providers of service, and other medical care plans.

IMPORTANT: By accepting benefits under the Sandia Total Health Program, you agree to reimburse payments made in error and cooperate in the recovery of excess payments.

Section 11. How to File an Appeal

This section outlines how to file an appeal with either BCBSNM or Express Scripts. The respective claims administrator will notify you of the decision regarding any appeal within the applicable time frames. Refer to Section 8, Claims and Appeals section of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#) for information on general appeal time frames under ERISA, as well as your right to information that you are entitled to receive from the claims administrator upon the denial of an appeal.

Filing an Appeal

IMPORTANT: Upon denial of a claim, dissatisfaction with the way a claim is paid, or the denial of a request for service, you have 180 calendar days of receipt of the notification of Adverse Benefit Determination to appeal the claim. You must exhaust the appeals process before you can seek other legal recourse.

If a request for service or a claim for benefits is denied in part or in whole, you have the right to appeal the denial. A request for further information (such as a diagnosis) from the provider of service is not a claim denial.

IMPORTANT: Regardless of the decision and/or recommendation of the claims administrator, Sandia Corporation, or what the Sandia Total Health Program will pay, it is always up to you and the doctor to decide what, if any, care you receive.

The table below outlines who to contact based on the reason for the claim denial:

If you have a claim denied because of...	Then...
Eligibility (except for incapacitation determinations)	See Eligibility Appeals Procedure in the NTESS Health Benefits Plan for Employees Summary Plan Description or the NTESS Health Benefits Plan for Retirees Summary Plan Description
Eligibility based on incapacitation determinations	Contact the claims administrator for assistance
Benefit Determinations	Refer to the procedures noted below

Before requesting a formal appeal, you may informally contact the claims administrator’s Customer Service. If Customer Service cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing at the address noted below (you may also call Customer Service and ask for assistance with your appeal). However, if you are not satisfied with a claim determination, you may appeal it as described below, without first informally contacting Customer Service.

If you are appealing an Urgent Care claim denial, please refer to Urgent Claims Appeals under BCBSNM or Expedited Appeal under Express Scripts.

If you disagree with a pre-service or post-service claim determination, you can contact the Claims Administrator by telephone or in writing to formally request an appeal. Written communication should include:

- Patient's name and ID number as shown on the ID card
- Provider's name
- Date of service
- Reason you think your claim should be paid
- Any documentation or other written information to support your request

You, your authorized representative (if you want someone to represent you in the appeal process, you must submit written authorization to BCBSNM designating the name of the person) or your doctor, can send the written appeal to:

Medical/Behavioral Health Appeals to:

BCBSNM Appeals Unit
PO Box 27630
Albuquerque, NM 87125-9815
Phone: 800-205-9926
Fax: 505-962-7541

Prescription Drugs Appeals to:

Express Scripts, Inc.
Attn: Pharmacy Appeals
Mail Route BL 0390
6625 West 78th Street
Bloomington, MN 55439
Fax: 877-852-4070

Prescription Administration Appeals to:

Express Scripts, Inc.
Attn: Administrative Appeals Department
PO BOX 66587
St. Louis, MO 63166-6587
Phone: 800-946-3979

Prescription Clinical Appeals to:

Express Scripts, Inc.
Attn: Clinical Appeals Department
PO BOX 66588
St. Louis, MO 63166-6588
Phone: 800-753-2851

BCBSNM Appeals Process

A qualified individual who was not previously involved in the claim decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a healthcare professional with appropriate expertise in the field who was not previously involved in the prior determination. BCBSNM may consult with, or seek the participation of, medical experts as part of the appeal resolution process. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim appeal for benefits.

Pre-Service and Post-Service Claim Appeals

You will be provided written notification of the decision on your appeal as follows:

- For appeals of Prior Authorization requests (as defined in [Section 10: How to File a Claim](#)), the first level will be conducted and you will be notified by BCBSNM of the decision within 15 calendar days from receipt of a request for appeal of a denied request. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to BCBSNM in writing within 60 calendar days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by BCBSNM of the decision within 15 calendar days from receipt of the request for review of the first level appeal decision.
- For appeals of post-service claims (as defined in [Section 10: How to File a Claim](#)), the first level appeal will be conducted and you will be notified by BCBSNM of the decision within 30 calendar days from receipt of a request for appeal of a denied or partially paid claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to BCBSNM in writing within 60 calendar days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified by BCBSNM of the decision within 30 calendar days from receipt of the request for review of the first level appeal decision.

Urgent Claims Appeals

Your appeal of a Prior Authorization or concurrent review denial may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. The appeal does not need to be submitted in writing. You or your physician should call BCBSNM at 877-498-7652 as soon as possible. BCBSNM will provide you with a verbal or written determination within 72 hours following receipt by BCBSNM of your request for review taking into account the seriousness of your condition.

Independent External Review Program

You or your authorized representative may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

- 1. Request for external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from BCBSNM, you or your authorized representative must file your request for standard external review with BCBSNM's Appeal Unit. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.
- 2. Preliminary review.** Within five business days following the date of receipt of the external review request, BCBSNM must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the healthcare item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the healthcare item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted BCBSNM's internal appeal process unless you are not required to exhaust the internal appeal process under the interim final regulations. Please read the [Exhaustion](#) section for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process the external review

You will be notified within one business day after BCBSNM completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, BCBSNM will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

- 3. Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, BCBSNM will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accredited organization. Moreover, BCBSNM will take action against bias and to ensure independence. Accordingly, BCBSNM must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the plan.
- Timely notification to you or your authorized representative, in writing, or the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to but may accept and consider additional information submitted after 10 business days.
- Within five business days after the date of assignment of the IRO, BCBSNM must provide to the assigned IRO the documents and any information considered making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by BCBSNM to timely provide the documents and information must not delay the conduct of the external review. If BCBSNM fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify BCBSNM and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to BCBSNM. Upon receipt of any such information, BCBSNM may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by BCBSNM must not delay the external review. The external review may be terminated as a result of the reconsideration only if BCBSNM decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, BCBSNM must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from BCBSNM.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by a decisions or conclusions reached during BCBSNM's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - Your medical records;
 - The attending healthcare professional's recommendation;

- Reports from appropriate healthcare professionals and other documents submitted by BCBSNM, you, or your treating provider;
 - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and use by BCBSNM, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to BCBSNM and you or your authorized representative.
 - The notice of final external review decision will contain:
 - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considering in reaching its decision;
 - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either BCBSNM and you or your authorized representative;
 - A statement that judicial review may be available to you or your authorized representative; and

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claims administrator, state, or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws, and you or your authorized representative.
- 4. Reversal of plan’s decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination of Final Internal Adverse Benefit Determination immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

- 1. Request for expedited external review.** BCBSNM must allow you or your authorized representative to make a request for an expedited external review with BCBSNM at the time you receive:
 - a. An Adverse Determination if the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability or care, continued stay, or healthcare item or serve for which you received Emergency services, but have not been discharged from a facility.
- 2. Preliminary review.** Immediately upon receipt of the request for expedited external review, BCBSNM must determine whether the request meets the reviewability requirements set forth in the Independent External Review Program section on page 99. BCBSNM must immediately send you a notice of its eligibility determination that meets the requirements set forth in the “Standard External Review” section above.
- 3. Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, BCBSNM will assign an IRO pursuant to the requirements set forth in the Independent External Review Program section on page 99. BCBSNM must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during BCBSNM's internal claims and appeals process.

- 4. Notice of final external review decision.** BCBSNM's contract with the assigned IRO must require the IRO to provide notice of final external review decision, in accordance with the requirements set forth in the Independent External Review Program section on page 99, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to BCBSNM and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if BCBSNM waives the internal review process or has failed to comply with the internal claims and appeals process. If you have been deemed to exhaust the internal review process due to BCBSNM's failure to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under state law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a healthcare service that you have already received until the internal review process has been exhausted.

Other External Actions

If you are still not satisfied after having completed the complaint, appeal, grievance, or reconsideration procedure, you may have the option of taking one of the following steps. No legal action may be taken earlier than 60 days after BCBSNM has received the claim for benefits or Prior Authorization request, or later than three years after the date that the claim for benefits should have been filed with BCBSNM.

External Appeal for ERISA Plans

If you are still not satisfied after having completed the complaint, grievance, appeal, or reconsideration process administered by BCBSNM (described above), you may have a right to bring a civil action under ERISA section 502(a).

Retaliatory Action

BCBSNM shall not take any retaliatory action against you for making a complaint or filing an appeal under this medical plan.

Appeals Process

Two levels of appeal are permitted for each type of claim that is denied (called an Adverse Determination). Appeal determinations will be rendered as specified Section 11: How to File an Appeal, of the [NTESS Health Benefits Plan for Employees Summary Plan Description](#) or the [NTESS Health Benefits Plan for Retirees Summary Plan Description](#).

Pre-Service and Post-Service Claim:

1. An appeal may be filed by you, your representative, or by a prescriber (on your behalf).
2. You, your representative or prescriber, on your behalf, may submit written comments, documents, records and other information relevant to your request for an appeal. All such information is taken into account during the appeal process without regard to whether such information was submitted or considered when making the initial Adverse Determination.
3. Upon initial receipt of an appeal, a clinical pharmacist will review the appeal (First-Level) and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, if the prescriber filed the appeal on your behalf, will be notified of the determination in writing.
4. If the clinical pharmacist does not overturn the Adverse Determination, Express Scripts will forward the appeal request to a physician (Second-Level) in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician must hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
5. If you are not satisfied with the decision following completion of the second-level appeal process, you may request that Express Scripts forward your appeal request to an independent review organization (IRO). You must submit this request within 120 calendar days of your receipt of the Second-Level appeal review denial. The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the appeal determination.
6. As with any Adverse Determination, approved clinical criteria will be employed to evaluate the claim under review during an appeal.
7. If within 5 working days after the filing date of the appeal there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified by written communication of the information required in order to process the appeal and directions on how to resubmit the appeal.

8. If any of the appeal reviews overturns the Adverse Determination, the benefit will be allowed.

Urgent Claims (Expedited) Appeal:

1. An expedited appeal may be filed by you, your representative or a prescriber, acting on your behalf. Contact Express Scripts customer service at 877-817-1440 to initiate an appeal.
2. The clinical pharmacist or physician reviewer, in discussion with you and/or independent third-party review organization, will determine whether the appeal constitutes an expedited appeal.
3. Upon initially receiving an expedited appeal, a clinical pharmacist will review the expedited appeal and may overturn the initial Adverse Determination, if appropriate. If the initial Adverse Determination is overturned, you and the prescriber, on your behalf, will be notified of the outcome in writing.
4. If the clinical pharmacist upholds the Adverse Determination, Express Scripts will forward the appeal request to an external Independent Review Organization (IRO). The IRO will engage a physician in the same profession and in a similar specialty that typically manages the medical condition, procedure, or treatment as mutually deemed appropriate. The physician reviewer will make the Appeal determination. The clinical pharmacist completing the review of the appeal and the reviewing physician will each hold an active, unrestricted license and board certification, if applicable, by the American Board of Medical Specialties (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctors of osteopathic medicine).
5. If within 24 hours after the filing date of the expedited appeal, there is not sufficient information to process the appeal, you, your representative or the prescriber, who filed the appeal on your behalf, will be notified verbally with a follow up in writing of the information required in order to process the appeal and directions on how to resubmit the appeal.

The decision on an expedited appeal will be rendered and communicated verbally within 24 hours of receipt of the appeal request.

Section 12. Sandia Total Health Administrative Services

Claims Administrators

The Claims Administrators are the third parties designated by Sandia to receive, process, and pay claims according to the provisions of the Sandia Total Health Program. For medical/surgical, behavioral health, and the Health Reimbursement Account this is BCBSNM.

Blue Cross and Blue Shield of New Mexico is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Claims Administrators are third parties designated by Sandia to receive, process, and pay claims according to the provisions of the Sandia Total Health Program. For medical and behavioral health claims, this is BCBSNM. Sandia delegates to the Claims Administrators the discretionary authority necessary to fulfill this role. The claims administrators have sole authority and discretion to determine whether submitted services/costs are eligible for benefits and to interpret, construe, and apply the provisions of their respective Program (with the exception of a claim that is applicable only to participant eligibility provisions which, except for incapacitated dependent status, are determined by Sandia) in processing and adjudicating claims. For more information, refer to [Section 10: How to File a Claim](#).

ConnectYourCare is the claims administrator for your Healthcare Flexible Spending Account (HCFSA) and Health Reimbursement Account (HRA). CYC is a subcontractor to BCBSNM.

Express Scripts is the claims administrator for Outpatient prescription drugs.

There are no claims associated with your Employee Assistance Program, but the service is provided by Magellan Health Services. Magellan Health is a subcontractor to BCBSNM.

BCBSNM Member Identification Cards

IMPORTANT: Always present your current Member identification card when obtaining healthcare. You have a Member ID card for healthcare services from BCBSNM, a debit card for prescription, dental and vision expenses from CYC and a Member ID card for prescription drugs from Express Scripts.

If you have elected single coverage, you will receive one Member ID card. If you have elected any other coverage, you will receive two Member ID cards. You may obtain additional ID

cards through by calling BCBSNM Customer Service at 877-498-7652. The Member ID card identifies you to providers as a covered Member. This card contains:

- Your name as the Primary Covered Member
- A unique subscriber (Primary Covered Member) ID number that has been assigned to you by BCBSNM and is linked to the Primary Covered Member's Social Security number in the BCBSNM system
- The group number
- The claims filing address
- On the back of your Member ID card you will find:
 - Customer Service phone numbers
 - Prior Authorization phone number for medical/surgical
 - Prior Authorization phone number for mental health/Chemical Dependency
 - 24/7 Nurseline assistance phone number
 - Blue Card Access phone number for national provider location
 - Connect Your Care (CYC) phone number for your FSA and HRA
 - EAP Magellan phone number for Prior Authorization, provider location, and assistance
 - MD Live phone number for provider Virtual Visits

Express Scripts Member Identification Cards

If you are a new enrollee in the Sandia Total Health Program, you will receive new Express Scripts ID cards. If you need additional identification cards, you may call Express Scripts Customer Service at 877-817-1440 and request them.

IMPORTANT: Always present your Express Scripts Member ID card when obtaining prescriptions at a retail pharmacy. If you do not use your card, you are not eligible to receive reimbursement for the prescription.

Blue Access for Members (BAM) Website

The BCBSNM Member website, bcbsnm.com/member, provides information at your fingertips anywhere and anytime you have access to the Internet. The BAM website offers practical and personalized tools and information so you can get the most out of your benefits. Once you have registered, you can:

- Learn about health conditions, treatments, and procedures
- Search for in-network providers and compare based on demographics, quality designations, etc.
- Access information on wellness topics

- Complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques, and access health improvement resources
- Use the treatment cost estimator to obtain an estimate of the costs of over 300 procedures nationwide
- Make real-time inquiries into the status and history of your claims
- View eligibility and benefit information
- View and print EOB statements online
- Print a temporary ID card or request a replacement ID card
- Update coordination of benefits status

Note: If you have not already registered as a BAM Member, go to bcbsnm.com/sandia and click on **Register Now**. Have your BCBSNM ID card ready for your Group and Member ID numbers.

Express Scripts Website

The Express Scripts Member website, www.express-scripts.com, provides information at your fingertips anywhere and anytime you have access to the Internet. This website offers practical and personalized tools and information so you can get the most out of your benefits. Log on to:

- Locate retail network pharmacies
- Price prescription drugs at retail network pharmacies and mail service
- Refill prescriptions through mail service
- Find out what drugs are covered under the Program

You can also access the above information on the Express Scripts Rx phone app from any smartphone. Simply enter Express-scripts.com into your smartphone browser or download the app by going to the Apple App Store, Android Market or Blackberry World.

Contact Telephone Numbers and Hours of Operation

Function	Telephone Numbers
DaVita Medical Group (formerly ABQ Health Partners) Ambassador Line – 505-262-7100	
BCBSNM – www.bcbsnm.com/member	
Customer Service <ul style="list-style-type: none"> • Claims questions • Check eligibility • Benefit information • Preferred (PPO) providers list • Case management 	877-498-7652 TTY 711 in New Mexico or outside NM call 800-746-7289 6:00 a.m. - 8:00 p.m. MT, Monday – Friday 8:00 a.m. – 5:00 p.m. MT Saturdays 4373 Alexander Blvd NE Albuquerque, NM
Connect Your Care (FSA and HRA administrator)	866-808-1444 http://www.connectyourcare.com/cyc2/

Function	Telephone Numbers
DaVita Medical Group (formerly ABQ Health Partners) Ambassador Line – 505-262-7100	
BCBSNM – www.bcbsnm.com/member	
BCBSNM Health Services <ul style="list-style-type: none"> • Medical/Surgical Prior Authorization 	800-325-8334 8:00 a.m. - 5:00 p.m. MT, Monday – Friday BCBSNM Medical Claims Address: BCBSNM P. O. Box 27630 Albuquerque, NM 87125-7630
BCBSNM Behavioral Health Unit <ul style="list-style-type: none"> • Mental health Prior Authorization • Chemical Dependency Prior Authorization • Claims • Inquiries 	888-898-0070 24 hours/day, 7 days/week BCBSNM Behavioral Health Claims Address: BCBSNM Behavioral Health P. O. Box 92165 Albuquerque, NM 87199-2165
BCBSNM Medical and Behavioral Health Appeals Address: BCBSNM Appeals Unit P. O. Box 27630 Albuquerque, NM 87125-9815 Phone: 800-205-9926 Fax: 800-773-1521	
Magellan Health Services <ul style="list-style-type: none"> • Employee Assistance Program (EAP) Prior Authorization • Participating providers 	800-424-0320 24 hours/day, 7 days/week
BCBSNM 24/7 Nurseline <ul style="list-style-type: none"> • Advice on medical care 	800-973-6329 24 hours/day, 7 days/week
Virtual Visits <ul style="list-style-type: none"> • Diagnoses & treatment on low acuity conditions 	Mdlive.com/sandia or mobile app 24 hours/day, 7 days/week
BCBSNM Onsite Representative <ul style="list-style-type: none"> • Escalated issues which the BCBSNM Customer Service toll-free number is unable to resolve 	505-284-8669 8:00 a.m. to 12 noon and 12:30 to 4:00 p.m. MT Mondays -Thursdays Sandia Benefits Office Bldg. 832, Room 40
Special Beginnings® Healthy Pregnancy Program provides information about: <ul style="list-style-type: none"> • nutrition • newborn care 	888-421-7781 8:00 a.m. - 5:00 p.m. MT Monday - Friday
Blue Distinction Centers for Specialty Care® <ul style="list-style-type: none"> • Bariatric Surgery • Cardiac Care • Complex and Rare Cancers • Knee and Hip Replacement • Spine Surgery • Transplants 	800-325-8334 http://www.bcbsnm.com/sandia/providers/blue_distinction.html
Blue365® Discount Program	http://www.bcbsnm.com/sandia/discounts.html

Function	Telephone Numbers
DaVita Medical Group (formerly ABQ Health Partners) Ambassador Line – 505-262-7100	
BCBSNM – www.bcbsnm.com/member	
Blue Access for Members (BAM) Help Desk <ul style="list-style-type: none"> Member website assistance 	888-706-0583 7 a.m. to 9 p.m. MT, Monday – Friday 6 a.m. to 2:30 p.m. MT, Saturday
BlueCard Access® <ul style="list-style-type: none"> Preferred (PPO) provider search while on travel BlueCard Doctor and Hospital Finder 	800-810-2583 (BLUE) www.bluecardworldwide.com
Express Scripts Prescription Drug Program– www.express-scripts.com	
Customer Service <ul style="list-style-type: none"> Refill a mail order prescription Determine if a pharmacy is in the pharmacy network Obtain information about your benefits Speak with a pharmacist about a prescription Request additional ID cards 	877-817-1440 24 hours/day, 7 days/week
Sandia National Laboratories – hr.sandia.gov	
HR Customer Service <ul style="list-style-type: none"> Forms General questions Benefit information Address changes 	505-844-4237 8:00 a.m. to 4:30 p.m. MT Fax: 505-844-7535
OneExchange <ul style="list-style-type: none"> PreMedicare Retiree Assistance Enrollment/disenrollment in retiree plans Address changes 	888-598-7809 www.SandiaRetireeBenefits.com

When You Change Your Address

When you move, you must change your address in the Sandia database. Active employees can change their address through Sandia’s internal website. Retirees need to change their address with OneExchange and Sandia Benefits.

If you move to California and wish to enroll in Sandia Total Health administered by Kaiser Permanente, you must enroll through Sandia Benefits (PreMedicare enroll through OneExchange) within 31 calendar days of the move.

Section 13. Definitions

Please note that certain capitalized words in this Program Summary have special meaning. These words have been defined in this section. You can refer to this section as you read this document to have a clearer understanding of your benefits.

<p>Adverse Benefit Determination or Adverse Determination</p>	<p>A denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a service. An Adverse Benefit Determination includes a decision to deny benefits based on:</p> <ul style="list-style-type: none"> • An individual being ineligible to participate in the Sandia Total Health; • Utilization review; • A service being characterized as Experimental or Investigational or not Medically Necessary or appropriate; • A concurrent care decision; and • For medical claims, certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at any time.
<p>Chemical Dependency</p>	<p>Conditions defined by patterns of usage that continue despite occupational, marital, or physical problems that are related to compulsive use of alcohol or drugs. Chemical Dependency (alcoholism and drug abuse) may also be defined by significant risk of severe withdrawal symptoms if the use of alcohol or drugs is discontinued. Chemical Dependency does not include nicotine addiction or alcohol use.</p>
<p>Coinsurance</p>	<p>The percentage of a Covered Health Service, which the Member pays after you've met the Deductible.</p>
<p>Congenital Anomaly</p>	<p>A physical developmental defect that is present at birth</p>
<p>Cost Effective</p>	<p>A procedure, service, or supply that is an economically efficient use of resources with respect to cost, relative to the benefits and harms associated with the procedure, service, or supply. When determining cost effectiveness, the situation and characteristics of the individual patient are considered.</p>
<p>Cosmetic Procedures</p>	<p>Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the claims administrator. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function, such as in breathing.</p>
<p>Covered Charge (applicable to medical plan)</p>	<p>The amount that BCBSNM allows for Covered Health Services using a variety of pricing methods and based on generally accepted claim coding rules. The Covered Charge for services from "contracted providers" is the amount the provider, by contract with BCBSNM (or another entity, such as another BCBS Plan), will accept as payment in full under this medical program. For Medicare-covered services, the Covered Charge is Medicare's Approved Amount for assigned claims, or the Medicare Limiting Charge (115% of the Medicare-Approved Amount) for non-assigned claims.</p> <p>Noncontracting Allowable Amount — The maximum amount, not to exceed billed charges that will be allowed for a covered service received from a noncontracted provider in most cases. The BCBSNM Noncontracting Allowable Amount is based on the Medicare Allowable amount for a particular service, which is determined by the Centers for Medicaid and Medicare Services (CMS).</p>

	<p>Medicare Allowable — The amount allowed by CMS for Medicare-participating provider services, which is also used as a base for calculating noncontracted providers' claims payments for some Covered Health Services of noncontracted providers under this medical plan. The Medicare Allowable amount will not include any additional payments that are not directly tied to a specific claim, for example, medical education payments. If Medicare is primary over this medical plan, and has paid for a service, the Covered Charge under this medical plan may be one of the two following amounts:</p> <p>Medicare-Approved Amount — The Medicare fee schedule amount upon which Medicare bases its payments. When Medicare is the primary carrier, it is the amount used to calculate secondary benefits under this medical plan when no "Medicare limiting charge" is available. The Medicare-Approved Amount may be less than the billed charge.</p> <p>Medicare Limiting Charge — As determined by Medicare, the limit on the amount that a nonparticipating provider can charge a Medicare beneficiary for some services. When Medicare is the primary carrier and a Medicare Limiting Charge has been calculated by Medicare, this is the amount used to determine your secondary benefits under this medical plan. Note: Not all Medicare-covered services from nonparticipating providers are restricted by a Medicare Limiting Charge.</p>
Covered Member	See Member.
Covered Health Services (applicable to medical plan)	<p>Covered Health Services are those health services and supplies that are:</p> <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing, or treating Illness, Injury, mental illness, Chemical Dependency, or their symptoms • Included in Section 6 of this Program Summary (subject to the limitations and conditions and exclusions as stated in this Program Summary) • Provided to you, if you meet the eligibility requirements as described in the booklet entitled NTESS Health Benefits Plan for Employees Summary Plan Description or NTESS Health Benefits Plan for Retirees Summary Plan Description and have enrolled into the Program • Medically Necessary/appropriate
Custodial Care	<p>Services or supplies, regardless of where or by whom they are provided, that a person without medical skills or background could provide or could be trained to provide or are provided mainly to help you with daily living activities, including (but not limited to):</p> <ol style="list-style-type: none"> 1. Walking, getting in and/or out of bed, exercising and moving 2. Bathing, toileting, administering enemas, dressing, and assisting with any other physical or oral hygiene needs 3. Assistance with eating by utensil, tube, or gastrostomy 4. Homemaking, such as preparation of meals or special diets, and house cleaning 5. Acting as a companion or sitter 6. Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications <ul style="list-style-type: none"> • Provide a protective environment. • Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve your Illness, Injury, or functional ability, or • Are provided for the convenience of you or the caregiver or are provided because your own home arrangements are not appropriate or adequate.

Deductible	Covered Charges incurred during a calendar year that you must pay in full before the Sandia Total Health Program pays benefits. Does not apply to covered, in-network Preventive Care or to Outpatient prescription drugs purchased through Express Scripts.
Developmental Care	<p>Services or supplies, regardless of where or by whom they are provided, that:</p> <ul style="list-style-type: none"> • Are provided to you if you have not previously reached the level of development expected for your age in the following areas of major life activity: <ol style="list-style-type: none"> 1. Intellectual 2. Physical 3. Receptive and expressive language 4. Learning 5. Mobility 6. Self-direction 7. Capacity for independent living 8. Economic self-sufficiency • Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Illness) or are educational in nature
Emergency	See Medical Emergency
Experimental or Investigational (applicable to medical plan)	<p>Experimental or Investigational Services: medical, surgical, diagnostic, psychiatric, Chemical Dependency or other healthcare services, technologies, supplies treatments, procedures, drug therapies, medications or devices that, at the time BCBSNM makes a determination regarding coverage in a particular case, are determined to be any of the following:</p> <p>Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;</p> <p>Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational);</p> <p>or</p> <p>The subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight</p> <p>EXCEPTIONS:</p> <p>Clinical trials for which benefits are available as described under clinical trials:</p> <p>If you have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Experimental or Investigational service to be a Covered Health Service for that Illness or condition. Prior to such consideration, BCBSNM must determine that, although Unproven, the service has significant potential as an effective treatment for that Illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.</p> <p>Refer to Section 7: Prescription Drug Program for Experimental or Investigational language for Express Scripts.</p>

Health Assessment	A Health Assessment is a confidential online questionnaire that asks you about health history, lifestyle behaviors (such as smoking and exercise habits) and your willingness to make changes.
Hospice	A program provided by a licensed facility or agency that provides home healthcare, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.
Illness	A disease, disorder, or condition that requires treatment by a physician. For a female Member, Illness includes childbirth or pregnancy. The term Illness as used in this Program Summary does not include mental illness or Chemical Dependency, regardless of the cause or origin of the mental illness or Chemical Dependency.
Injury	Bodily damage from trauma other than Illness, including all related conditions and recurrent symptoms.
Inpatient Stay	An uninterrupted confinement of at least 24 hours following formal admission to a hospital, Skilled Nursing Facility or inpatient rehabilitation facility.
Intensive Outpatient Program	A program that provides 9 to 20 hours per week (less than four hours per day) of professionally directed evaluation and/or treatment.
Maintenance Care	Treatment beyond the point where material or significant improvement is to be expected. The treatment results in no measurable or objective improvement. For modality treatments, such as Nonsurgical Spinal Treatment or physical therapy, the treatment provides no evidence of lasting benefit; treatment provides only relief of symptoms.
Medical Emergency	An accidental Injury or a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) serious jeopardy to his/her health (or, if pregnant, to the unborn child); 2) serious impairment to the bodily functions; or 3) serious dysfunction of any bodily organ or part. (In addition, services must be received in an Emergency room, trauma center, or ambulance to qualify as an Emergency.)
Medically Necessary or Medically Appropriate (applicable to medical plan)	<p>A service or supply that is ordered by a physician, the medical director, and/or a qualified party or entity selected by BCBSNM, and determined as:</p> <p>Provided for the diagnosis or direct treatment of an Injury or Illness</p> <p>Appropriate and consistent with the symptoms and findings or diagnosis and treatment of your Injury or Illness</p> <p>Provided in accordance with generally accepted medical practice on a national basis</p> <p>The most appropriate supply or level of service that can be provided on a Cost-Effective basis including, but not limited to, inpatient vs. Outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care</p> <p>Allowable under the provisions of the Sandia Total Health Program as prescribed by your physician.</p> <p>IMPORTANT: The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply Medically Necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in the Sandia Total Health Program.</p>

Medicare-Approved Amount (applicable to medical plan)	The Medicare fee schedule amount upon which Medicare bases its payments. This amount may be less than the actual amount charged by the provider. The out-of-network coverage for Covered Health Services under the medical plan is based on 100% of the Medicare-Approved Amount.
Member	An enrolled participant or enrolled family member. This term refers to a person only while enrolled under the Sandia Total Health Program. References to “you” and “your” throughout this document are references to a Member.
Non-preferred Provider	A provider that is not contracted with a BCBS Plan to be part of the BCBS Preferred Provider network.
Nonsurgical Spinal Treatment	Detection or nonsurgical correction (by manual or mechanical means) of a condition of the vertebral column, including distortion, misalignment, and subluxation to relieve the effects of nerve interference that results from or relates to such conditions of the vertebral column.
Out-of-Pocket Maximum or Out-of-Pocket Limit	Your financial responsibility for covered expenses before the Sandia Total Health reimburses additional Covered Charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Outpatient	A person who visits an office, a clinic, Emergency room, or health facility and receives healthcare without being admitted as an overnight patient (under 24-hour stay).
Outpatient Surgery	Any invasive procedure performed in a hospital or surgical center setting when a patient is confined for a stay of less than 24 consecutive hours.
Partial (or day) Hospitalization	A program that provides Covered Health Services to persons who are receiving professionally directed evaluation or treatment and who spend only part of a 24-hour period (but at least four hours per day) or 20 hours per week in a hospital or treatment center.
Prior Authorization	The process whereby you and/or your physician call to obtain prior approval for certain healthcare services and employee assistance program benefits.
Preferred Provider	Healthcare professionals and facilities that have contracted with BCBSNM, a BCBSNM contractor or subcontractor, the BCBS Association, or another BCBS Plan as “preferred” (PPO) providers. An “HMO” or a “participating-only” provider is not a Preferred Provider under the medical plan. When scheduling an appointment for “in-network” services, ask if the provider is a BCBS “Preferred Provider.”
Primary Covered Member	The person to whom the coverage is issued; that is, Sandia employee, retiree, surviving spouse, Long Term Disability Terminatee or the individual who is purchasing temporary continued coverage.
Residential Treatment Facility	A Residential Treatment Facility provides acute overnight services for the care of a Chemical Dependency disorder or overnight mental health services for those who do not require acute care.
Skilled Nursing Facility	A nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a hospital is considered a Skilled Nursing Facility for purposes of the medical plan.
Sound Natural Teeth	Teeth that are whole or properly restored; are without impairment or periodontal disease and are not in need of the treatment provided for reasons other than dental Injury.
Specialist	Any physician who is devoted to a medical specialty.

<p>Unproven Services (applicable to medical plan)</p>	<p>Health services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.</p> <p>Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.</p> <p>Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.</p> <p>BCBSNM has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, BCBSNM issues medical and drug policies that describe the clinical evidence available with respect to specific healthcare services. These medical and drug policies are subject to change without prior notice.</p> <p>Note: If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), BCBSNM may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that illness or condition. Prior to such a consideration, BCBSNM must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.</p> <p>BCBSNM may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Member with an illness or injury that is not life-threatening. For that to occur, all of the following conditions must be met:</p> <ul style="list-style-type: none"> • If the service is one that requires review by the U.S. Food and Drug Administration (FDA), • It must be FDA-approved • It must be performed by a physician and in a facility with demonstrated experience and expertise • You must consent to the procedure acknowledging that BCBSNM does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective • At least two studies must be available in published peer-reviewed medical literature that would allow BCBSNM to conclude that the service is promising but Unproven • The service must be available from a network physician and/or network facility • The decision about whether such a service can be deemed a Covered Health Service is solely at BCBSNM's discretion. Other apparently similar promising but Unproven Services may not qualify.
<p>Urgent Care</p>	<p>Treatment of an unexpected illness or injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection.</p>
<p>Urgent Care Center</p>	<p>Can be attached to a hospital or be freestanding, staffed by licensed physicians and nurses, and providing healthcare services.</p>

Section 14. Blue365

Blue365 is just one more advantage of being a Blue Cross and Blue Shield of New Mexico (BCBSNM) Member. With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations.

With discounts on health-related products, along with discounts on health and fitness clubs, weight-loss programs and so much more, you can decide what choices are right for you while saving money.

- **Receive discounts, promote your health** – Discounts and offers from national and local health and wellness companies encourage mind and body wellness.
- **Share the health** – Blue365 can make living well a family activity, with deals for gym discounts, well-balanced meal ideas and more.
- **Be in the know** – After you register, you'll get weekly deals delivered straight to your inbox, helping you focus on your health.

Once you sign up for the Blue365 website at <http://www.bcbsnm.com/sandia/discounts.html>, you will receive weekly “Featured Deals,” via email.

Sandia National Laboratories is providing the following information strictly as a convenience to BCBSNM Members. Sandia cannot guarantee any discounts, results, or performance for the discount programs. The discounts and services available to Members may change at any time and Sandia and BCBSNM do not guarantee that a particular discount or service will be available at a given time.